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AUGUST 1963

GOVERNMENT AND MEDICINE IN THE UNITED STATES

REGULAR FEATURES

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Coming Next Month

September, 1963

COMMUNIST CHINA

In September we shall turn to a review of developments in Communist China. Seven specialists evaluate Communist China's foreign and domestic programs in the following articles:

Conflict in the Sino-Soviet Bloc

by MILTON KOVNER, Lecturer on Soviet Affairs, School of Advanced International Studies, Johns Hopkins University;

China and Japan

by PAUL LANGER, Rand Corporation;

Sino-Indian Border Conflict

by WERNER LEVI, Professor of Political Science, University of Hawaii, and author of "Modern China's Foreign Policy";

China's Offensive in South Asia

by BERNARD B. FALL, Associate Professor of Government, Howard University, and author of "Street Without Joy: Indochina at War";

Chinese Communist Ideology

by SHEN-YU DAI, Assistant Professor of Political Science, Northern Illinois University;

China's Industrial Development

by YUAN-LI WU, Research Associate, Hoover Institution, Stanford University;

The Chinese Farmer

by TED HERMAN, Department of Geography, Colgate University.

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CURRENT History

AUGUST, 1963 VOL. 45, NO. 264

This issue contains an eight-article survey of health services in the United States and the extent of governmental responsibility in this field. The nation's health today is constantly improving and health services are generally effective. Yet as our introductory article points out, "our health services are now under enormous strains as a result of their own successes during the past 30 years." The problem of financing and supervising these services is "being examined and discussed endlessly."

The Nation's Health

By Odin W. Anderson

Associate Professor, Graduate School of Business and Department of Sociology University of Chicago

For many years there has been continuous discussion and debate on how health services in the United States should be organized, distributed, and paid for. Underlying this concern has been the basic issue of the extent to which the health services should be the responsibility of government. At present three-quarters of the total expenditures for health services are from non-governmental sources, a proportion which has remained stable for about 20 years. As measured by total expenditures, non-governmental efforts continue to shape the destiny of our health services, with government as a supplementary rather than as the main source of financial support and policy.

There are important differences, however, in responsibilities assumed by governmental and non-governmental sectors to assure that both the community as a whole and individual families are protected from disease and its costs. Protecting the community from ravages of communicable disease and a dangerous physical environment has been accepted as a governmental responsibility for a long time; the protection of the individual family from the possibility of bankruptcy because of expensive illnesses is not in the main regarded as a responsibility of government, although government does not ignore this problem.

The division of responsibility between the governmental and the non-governmental sectors of the American economy is an expression of a political and social philosophy as to how a necessity like health services can best be made available to all the people. Health services are "clothed with the public interest." Implicit in this philosophy is the doctrine that no person who is sick should be turned away from a hospital door because he has no money, although he can legitimately be refused a television set if he cannot pay for it. Health services clearly are not regarded as just another consumer item to be sold and paid for in the market place, though three-quarters of our total outlay for health care comes from private sources.

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This situation is not so paradoxical as it may seem. Our society uses many methods to achieve its ends, from a government monopoly like the post office to a purely private enterprise like a mail order house. There is a consensus that all people should in some way be protected from hazards of the environment out of their individual control and should have reasonably easy access to health services; there is much less consensus as to how this should be achieved. The development and present structure of our health services reflect directly the relationship of ends and means.

The main framework of our health services was established by 1920. Thereafter the chief problem has been one of devising methods to pay for the day-to-day costs of care, the costs of training personnel, and the continuing costs of constructing facilities. Further, there has been pervasive concern with improving the quality of the services. Much less consensus exists regarding the need to reorganize the present structure of hospital and physicians' services although the problem arouses a great deal of discussion and many attempts at innovation.

In the United States, the health services system has evolved without hindrance from a set of conditions that were present during the last quarter of the nineteenth century. The discovery of bacteria led to asepsis in hospitals and control of post-operative infections. The discovery of anesthesia made surgery possible. Surgery needed equipment that could be assembled only in a place like a hospital. Control of infections and alleviation of pain, then, resulted in the tremendous growth in general hospitals from 1875 to 1920. The general hospitals were financed largely by private capital, i.e., philanthropy, and some famous ones were financed by local government, particularly in cities like New York, Chicago, and Philadelphia. The general hospital system developed outside public taxation and direct public control and for its support depended on private pay patients, part-pay patients, and contributions from private charity organizations for patients who could not pay.

The underlying political and social values described above have direct influence on the development of the current arrangements of health services in this country. They particularly affect ownership and financing of facilities, methods of access of patients to hospitals, physicians, and dentists, and methods of payment. The facilities and services can be briefly classified as follows:

1. General hospitals for short-term illness episodes.
2. Physicians.
3. Dentists.
4. Drugs and medications.
5. All other.

These services and facilities evolved almost wholly outside of the governmental sector. This statement must be qualified, however, because a small portion of the general hospitals are owned by various levels of government, about a quarter of the funds for building and renovating general hospitals come from the federal and local governments, and roughly one-half of the physicians and dentists are trained in state-supported universities. Virtually all the mental and tuberculosis hospitals are financed and owned by state and federal governments.

Since 90 per cent of the patients in all hospitals use the general hospitals during a year, the discussion will henceforth be limited to the hospital services that provide short-term care. The long-term hospitals ordinarily care for patients with mental disease and tuberculosis. Although approximately one-half of all hospital beds in this country are in mental hospitals (and a small and diminishing fraction in tuberculosis hospitals) the problems presented by these hospitals are so different from those in general hospitals that they require a separate description not wholly pertinent to the subject of this article. They usually receive separate attention from study commissions and legislatures.

In the last reported fiscal year of the federal government, 1960–1961, over $29 billion was spent for all health services in this country: direct services, construction

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and renovation of facilities, research, education, and environmental sanitation and communicable disease control. This total was split between all levels of government, 24 per cent, and private expenditures, 76 per cent. For the time being, however, we shall deal with expenditures for direct services only, i.e., care given to individual patients, usually called personal health services. The total outlay for direct services was almost $26 billion, of which 21 per cent came from various levels of government and 79 per cent from private sources:

	Per cent expenditures 1960–1961
Private sector	79
Direct payment by patients	55
Insurance benefits	21
Other	3
Public sector	21
Hospital and medical care	9
Associated with defense	7
Public assistance	2
Other	3
	100 (rounded)

For direct services the discussion will be limited to the private sector, because it is in this sector that the important discussions in public policy are taking place. Other aspects of the total health services establishment are also receiving attention, such as the supply of physicians, dentists, and hospital beds, and will be dealt with later. They need to be discussed in another context because of an increasingly heavy involvement of tax funds and because they deal with problems of supply of services rather than the purchasing of services.

In the non-governmental sector of expenditures for direct services the present distribution of the "medical dollar" by type of service is as follows:

	Per cent
Hospital	29
Physician	29
Dentists	10
Drugs and medications	20
Other	13
	100 (rounded)

The share of the medical dollar going to hospitals has been increasing steadily during the past 30 years and reflects the increasing importance of this facility among the personal health services. Expenditure for all other services has also been increasing so that at the present time families are now spending 6.6 per cent of their total annual budgets on all personal health services, or approximately $120.00 per person per year, including the portion paid by health insurance. This increase has resulted from higher prices for the services and from greater use.

Over the past 30 years admissions to the general hospital have increased from 60 per 1,000 population per year to 130. The number of physicians' visits per person per year has gone up from two and one-half to over five. The increased demand on the health services has been persistent and is still continuing. Concurrently, various forms of insurance to help families pay for some of these services have grown from an enrollment of only several million people in 1940 to over 70 per cent of the population today.

Insurance is popular because costs of personal health services fall very unevenly on families in a year. Insurance, therefore, helps to spread this cost over many people. A revealing figure, for example, shows that in one year 10 per cent of the families incur 40 per cent of the total expenditure. Or, again, in one year about five per cent of the families have expenditures for personal health services of $1,000 or more. Today, around 25 per cent of total expenditures for personal health services are covered by insurance, but families with high costs have a larger percentage of their expenditures covered than families with low costs. This is a very gross measure because it is not assumed that insurance should cover 100 per cent of expenditures. By type of service, insurance now pays 66 per cent of all private expenditures for hospital service and 32 per cent of physicians' services. In 1948, the corresponding percentages were 27 and 6.

There is a broad consensus that insurance should cover a wider range of services and particularly almost all of family expenditures

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beyond certain magnitudes—the kind of expenditure referred to as "catastrophic." There are controversies regarding how a broader range of services should be covered, and how services, particularly physicians' services, should be organized. These controversies lead to a description of the present and prevailing arrangements of personal health services and the innovations that have taken place.

FACILITIES AND PERSONNEL

When a person feels he needs a physician, he has a range of sometimes bewildering alternatives which are highly valued by the general population and providers of services. He can go to his usual physician (in a nationwide survey conducted in 1955, 80 per cent of the adults named a physician they would go to if they were sick). This physician may be a general practitioner or a specialist. Or the person may go to a clinic or out-patient department of a hospital. The physician may refer the patient to a specialist or hospital diagnostic facility. When the treatment period is over, the patient pays the physician's fee and hospital charges, either by means of insurance, directly from his own resources, or by a combination of both.

Other health services and goods like dental care and drugs are not usually covered by insurance so the patient pays the entire charge. If the patient is receiving public assistance, the states and cities usually provide care through tax supported programs with some help from the federal government. The chief characteristics of this system, then, are the patient's privilege of choosing a physician, whether general practitioner or specialist, and the physician's privilege of making a referral to a specialist or a hospital.

The standards for the health services system are maintained by a variety of informal and formal methods. The medical schools are accredited by the American Medical Association, and physicians are licensed by the various states. Those who wish to specialize go in for longer training periods and then take examinations given by the various specialty groups to attain specialty board status. Nurses are licensed by the various states after specified periods of training. Dentists follow the same pattern as physicians. Drugs and medications are supplied by licensed pharmacists in retail drug stores, although many hospitals have their own pharmacies. Standards are maintained by the pharmaceutical houses and the Federal Food and Drug Administration.

Physicians locate where they believe they can be near medical facilities and in areas where they can expect to attract patients. Hospitals have been built in locations where it has been believed there is sufficient need for them and where there is sufficient financial support for daily operation. Since World War II the Hospital Survey and Construction Act, established in 1946, has encouraged the states to assess their total hospital needs in seeking federal funds to be matched by the states and voluntary contributions. Dentists, like physicians, establish practices where they believe they will attract patients. Nurses are largely located in areas where there are hospitals, unless they work in industry, public health departments, or visiting nurse associations. The health services establishment is supplied equipment, drugs, bandages, and dressings, and a host of related health service goods, by hospital and medical supply firms and the pharmaceutical industry.

The manpower and facilities needed to serve the population are tremendous by any standards. Over 2.5 million people, or 3.5 per cent of all employed persons, are engaged in the health services industries. At present the ratios of facilities and personnel to population are as follows:

One physician to every	750 persons
One hospital bed to every	280 persons
One dentist to every	1,750 persons
One pharmacist to every	1,500 persons
One active registered nurse to every	350 persons

The total investments in the health service establishment are also tremendous, but difficult to estimate. Almost all of the physicians and dentists in private practice own their

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office equipment and rent or own the office space.

There is now general concern with the supply of physicians, dentists, nurses, and other professional health personnel and with our ability to maintain their number in relation to the inevitable increases in population. It is generally assumed that the present ratio of personnel to population should remain unchanged in view of the still increasing demand for services of all kinds. For the time being the population is increasing faster than personnel, and efforts are being made to establish more medical and dental schools and also to expand the facilities of existing schools. Legislation is now being considered in Congress to assist in financing educational facilities and providing scholarships to attract recruits. The supply of general hospital beds has kept up well with increasing population; our construction know-how makes this possible, but the recruitment and training of personnel is a much more complicated and long-range problem.

Many believe that our health services can be reorganized to make more efficient use of physicians, nurses, and hospitals by encouraging physicians to practice in groups with the range of specialties represented in each group. This reorganization would concentrate diagnostic facilities and office personnel, and facilitate quick consultation among specialists on many patients who in the course of diagnosis and treatment may need to see several physicians.

There are now many examples of this type of arrangement. A few of them are also associated with some form of insurance plan combining group medical practice and insurance to cover virtually all physicians' services. So far, however, only about seven per cent of the physicians in private practice are in some form of group practice, the other 93 per cent are in so-called "solo practice." Group practice associated with an insurance plan is a form of organization that has been growing gradually during the past 20 years, but less than four per cent of the population is enrolled in this type of arrangement. The attention these plans evoke from physicians in the prevailing form of practice is intense.

Since there is no official policy regarding how the health services should be organized and paid for—other than the broad divisions between the governmental and private sectors that have been described—the health services establishment in this country has evolved a variety of methods to provide and finance health services. Consequently, there is constant trial-and-error experimentation and proponents of various approaches take their stands. The resulting ferment permits opportunity for a study of the alternatives probably not given to any other country.

HEALTH SERVICES AND HEALTH

It is a truism that the health services have been developed to prevent and cure disease, alleviate pain, and arrest disease that cannot be prevented or cured. Methods of payment have developed in order to give families an opportunity for orderly budgeting of costs of health services in advance since serious illnesses are unpredictable.

It is generally assumed that the level of health of the population has risen during the past 60 years, and that a good part of this improvement can be attributed to health services along with improved diet, housing, and working conditions. There are also many allegations that our current death and disease rates are still higher than they need to be. Claims are made that if our health insurance plans were improved, if many of the services were organized in other ways, and checks were made on quality of care, diseases could be controlled and deaths postponed even more than they are today.

These allegations are both difficult to prove and to challenge because our methods of measuring health levels are, at best, very crude. It is known, of course, that the leading causes of death have changed dramatically during the past 60 years from tuberculosis, pneumonia, influenza and other infections and communicable diseases to heart disease, cancer and accidents.

Concomitantly, the kinds of diseases in the population have also changed because of prevention and cure of many infectious and

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communicable diseases. A special problem is dental caries. This condition continues to plague virtually the entire population. Dental needs, short of dramatic conditions like loss of teeth and crooked teeth, do not seem to concern people as does care requiring physicians' services.

Surveys of illness over the last 40 years indicate, however, that the rate of disease has remained the same. Improved health services and living conditions generally plus a population that knows how to use the services results in a change in disease and death patterns. Disease and death as such are, of course, not eliminated.

It is interesting to speculate what would happen to death rates if our present know-how in prevention and cure were applied under optimum conditions: i.e., all who needed services would *seek* and *receive* them; all physicians would diagnose and treat with perfection; all patients would follow their physicians' recommendations to the letter; and society would allocate all necessary resources to this purpose. Some crude, but probably indicative, data can be presented.

It is theoretically possible to eliminate almost all deaths from communicable and infectious diseases by applying present medical knowledge and existing agents of prevention, cure, and control. In 1900 around 35 per cent of all deaths were due to these causes; now this proportion has been reduced to five per cent, mostly since 1935. The other 95 per cent of the deaths are regarded as relatively unpreventable, although under optimum management they might be delayed longer than at present.

In a medical survey of the general population in Hunterdon County, New Jersey, a few years ago, a medical team making physical examinations determined that only six out of 100 conditions disabling enough to interfere with a person's accustomed activities could have been prevented. Further, only 30 out of 100 of the diagnosed conditions could have been prevented from advancing to the stage in which they were found. This gives us a rough but suggestive estimate of the extent to which modern medical care can have an effect if fully applied under optimum conditions, i.e., good doctors, adequate facilities, and cooperative patients. The proper prevention, control, and management of disease today requires a great deal of initiative and cooperation from the patient, because only the patient can initiate the seeking of care.

After the patient seeks care, great skill, compassion and patience are required to control and manage prevailing diseases with the enormous and myriad medical technology we now possess. To a great extent, then, the effectiveness of our health services should be judged less by the deaths that might still be postponed—because of the low death rate already attained—but more by the extent anxiety is relieved, pain alleviated, and the patient assisted in adjusting to disabilities that inevitably occur as one gets older. This concept of health level is difficult and perhaps impossible to measure, but it points to the uselessness of death and illness figures as a measure of health levels now that the scourges of 60 years ago are under control. It is equally difficult to put a price tag on adequate health services because concrete results are increasingly difficult to measure. It is, therefore, in the public interest to err on the side of generous rather than tight financing to permit a margin of safety.

OBSERVATIONS AND CONCLUSIONS

Our health services are now under enormous strains as a result of their own successes during the past 30 years. As measured by changes in the causes of death and morbidity within the memory of many living today, there is a general consensus that enormous

(*Continued on page 117*)

Odin W. Anderson is research director of the Health Information Foundation at the University of Chicago. He served as the research director of the Health Information Foundation in New York City from 1952 to 1962; during this time he held successive appointments in sociology and public health at New York University and Columbia University.

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"In the first century of its existence the federal government exercised almost no function with respect to individual or public health," notes this specialist. He points out that "historically, . . . the entering wedge for direct individual medical help to civilians by the federal government came by way of aid to veterans of the armed services."

Government and Health before the New Deal

By William G. Carleton
Professor Emeritus of History and Political Science, University of Florida

At no time in American history has any unit of government—local, state or federal—taken general responsibility for aiding nonindigent individuals in time of sickness. Until after the Civil War, even the state and local governments did relatively little in the way of sanitation and public health.

During the colonial period only alarming epidemics like smallpox and yellow fever aroused communities to take civic action. At such times a local committee would be organized to evacuate the unaffected population to the countryside or to other communities, and the members of the committee, along with others who had previously had the disease, stayed behind and waged the fight against the plague. Fires would be kept burning in the streets, and very often gunpowder was exploded. Homes were "fumigated" by the burning of tar or sulfur, and often household articles and clothing were burned to prevent contamination. Frequently, neighboring communities would organize "shotgun patrols" to prevent refugees from the epidemic areas from coming near their own communities.

The earliest continuous intervention by government in the interest of public health was legislation by some of the colonial governments to prevent the spread of disease from "sickly vessels" arriving in port towns. Masters of ships were subjected to heavy fines for bringing such vessels into port or for failing to report sickness aboard. Coastal towns appointed quarantine officers to enforce these laws, to inspect ships, and to quarantine infested ships in the roadsteads. Later, some of the colonial port towns built marine pest houses on sandy wastes or isolated islands to care for passengers and crews taken from contaminated ships. Still later, pest houses were built for local residents suffering from epidemic diseases. Sometimes the local quarantine officer became the local health officer charged with marine inspection, the marine pest house, the local pest house, and with isolating families and fumigating homes where there had been smallpox. The remuneration of the quarantine or health officer and the costs of maintaining the pest houses were borne by subsidies from the colonial governments, local private subscriptions, and local lotteries.

In colonial times there were few hospitals. For the most part these were confined to the larger port cities and ministered only to the homeless, to seamen, refugees, runaway slaves and the destitute. Hospitals were financed by private subscription, local lotteries and,

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in a few cases, by subsidies from colonial governments. Sometimes local doctors or a religious parish would for a time maintain a local hospital for the chronically ill or the destitute. The oldest general hospital in the United States was established in Philadelphia in 1751 when the Pennsylvania Assembly agreed to "match" funds of Philadelphia citizens raised by private subscription.

Colonial governments took no responsibility for the training of physicians or even for their licensing. It is estimated that at the end of the Revolutionary War there were about 3,500 medical doctors in the United States, but less than 400 of these had received a medical degree. Most of those with a medical degree had been trained in Europe. These became preceptors for medical students. A person who wanted to become a doctor became an apprentice to an established doctor who directed the apprentice's reading and used him as a helper in his practice. Medical education was thus "in training" education. Most people never saw a doctor, and even those who did commonly relied on midwives, home remedies, family or neighbor aid, folklore, and quacks.

1789–1865

With the establishment of the federal government in 1789, matters of medical education, licensing of physicians, the building and maintenance of hospitals, care of the indigent sick, and public sanitation and public health were left almost entirely to state and local governments. Until after the Civil War the states and localities actually did relatively little about such matters. Reliance was placed on private enterprise, public-spirited doctors and citizens, and religious and other voluntary organizations.

During the first part of the nineteenth century the most common diseases and the great killers were not degenerative disorders but communicable diseases. The discoveries of bacteriology and epidemiology were still in the future. Only smallpox was beginning to yield to immunization. Tuberculosis, pneumonia, dysentery, diarrhea, typhoid, malaria, diphtheria, scarlet fever, venereal disease and puerperal (childbirth) fever were common. Until about 1875, there were still some serious epidemics of smallpox, and the most devastating waves of yellow fever and Asiatic cholera occurred during the early and middle nineteenth century.

In rapidly expanding frontier America there were vast areas of freshly cleared and undrained land. Every hamlet had its stagnant millpond. In towns there were cesspools and open privies. In rural areas people often had no privies at all and used the open fields and streams. Houses were not screened from flies, mosquitoes or fleas. Bedbugs and body lice were common. There were few community water systems and even fewer public sanitary sewage systems. The diet in large areas of the country was predominantly salt pork and corn meal; in this pre-refrigeration age, much food was contaminated and adulterated; and people swilled vast quantities of alcohol and patent medicines. In the new mill towns, people worked long hours for low wages and lived under crowded and filthy conditions.

In the 1840's and the 1850's, immigrants poured in from Europe, and slums in the seaport cities grew. The increased mobility provided by roads, by canals, and by railroads spread communicable diseases from community to community. The increase in world trade and the larger number of ships in American ports coming from Latin America and Asia brought epidemics of yellow fever and Asiatic cholera.

Medical science was slowly making progress, but doctors still practiced blistering and bleeding and depended heavily on mercury, arsenic, opium, and other poisons and on violent purges and cathartics. Most Americans, living on isolated farmsteads and plantations, relied on home guidance medical books, midwives, roots and herbs learned from tradition and from the Indians, patent medicines, and the "wonder remedies" hawked at carnivals and fairs by colorful spielers.

The training and licensing of physicians were left largely to the local medical societies. Increasingly, during the early and middle nineteenth century, local medical societies

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established proprietary schools. These were in no way connected with a university or college. Little preparatory education was required; courses were inadequate; and certification from one of these schools entitled the graduate to practice medicine. Reputable medical colleges connected with universities were growing, but the vast majority of American doctors came out of the proprietary schools. Thus the state governments assumed little responsibility for training doctors, refused to regulate medical education, and allowed the licensing power to be exercised by the proprietary schools and the local medical societies, most of whose members feared that the raising of educational standards would jeopardize their own positions.

The first widespread government health measures were public regulations to rid communities of nuisances which produced bad odors. Behind this was the theory of miasmata as the cause of disease. This theory, which prevailed in the late eighteenth century and well into the nineteenth century, held that disease came from the air by way of bad odors from slaughter houses, tanneries, decaying vegetable and animal matter, privies, cesspools, duck ponds, pigsties, stagnant waters, marshes and so forth. Smallpox was realized to be a truly contagious disease, but there was little understanding of the other communicable diseases, how they were transmitted from person to person, how agents might be carried by body lice, fleas, flies, mosquitoes, or appear in water and food that looked and smelled clean. During the early and middle nineteenth century most communities passed ordinances requiring the removal of filthy and evil-smelling nuisances or action to make them less foul-smelling. These ordinances were usually enforced by the ordinary local police officials, although a few communities established a local health officer or local board of health, almost always with little or no trained personnel. Thus miasmata, a false concept, led to government measures which inadvertently struck at many of the breeding places of disease.

In 1817, there were 17 community water supply systems in the United States, and 16 of these were owned and maintained by private companies. By 1860, 148 communities had public water supply systems and around 40 per cent of these were owned by city or other local governments. Community sanitary sewage systems came somewhat later than community water supplies, but beginning around 1850 there was a noticeable increase in such systems. For the most part, the early sewage systems and disposal plants, like the community water supply systems, were owned and operated by private companies. Gradually these, like the water systems, were taken over by local governments.

A remarkable development of the 1840's was the assumption by many state governments of the care of the insane and mentally ill. Up to that time, these unfortunates were left with their families or poorly treated or mistreated in jails, prisons, and almshouses. By around 1850, 20 states had built and undertaken to maintain "asylums" for the insane. The crusade of Dorothea Dix was largely responsible for this momentous expansion of government responsibilities for the handicapped.

SANITARY CODES

During the 1850's ideas of environmental sanitation gained headway. Many more communities adopted sanitary codes, and such codes were greatly expanded in their coverage. At the same time, a strong movement was afoot to establish a national maritime and quarantine code. There were numerous state and national conferences on sanitation and quarantine. The outstanding leader in the field was Lemuel Shattuck of Massachusetts, who in turn was greatly influenced by the pioneers of public health in Europe. Most public health agitation was cut short by the Civil War, but it bore fruit afterward, and the great concentration of masses of men in the armies during the war itself added greatly to the American knowledge of sanitation, "crowd diseases," and nutritional ailments, and emphasized the need for state and local sanitary codes in civilian life.

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In the first century of its existence the federal government exercised almost no function with respect to individual or public health. In 1796, an attempt was made to have Congress pass a law under which the federal government would make uniform national regulations covering maritime quarantine and enforce them. But states rights forces were too strong; the bill was defeated and maritime quarantine was left primarily to the states. However, a law was passed authorizing federal revenue officers to cooperate with each state in the execution of its maritime regulations.

Another conspicuous rejection of federal activity came in President Pierce's administration when Congress, in response to Dorothea Dix's lobbying, surprisingly passed a bill to set aside federal land for grants-in-aid to the states to build and support insane asylums. Pierce vetoed the bill on the grounds that it would weaken state and local responsibilities.

However, the federal government assumed a few functions with respect to health. In 1798, Congress established the United States Marine Hospital Service for sick and disabled seamen; twenty cents a month was deducted from the wages of each seaman. This was the first example in American history of "social security." Each port of the United States had a federal director of marine hospitals, and the port's federal director of customs, under the United States Treasury, collected and administered hospital funds and supervised the director. The hospital service was usually contracted to private enterprisers and was generally inefficient. Since the collectors of customs and the directors of hospitals were usually products of the political spoils system, there were all sorts of complaints of political favoritism and misuse of funds.

The federal government made a significant contribution to the understanding of general health in the nation when its 1850 Census for the first time included a breakdown of the causes of death. Subsequently each national census became more complete and accurate. Such information was indispensable to health officers and students of public health, and the national census stimulated cities and counties to set up registrations of births and deaths.

Early in the course of the Civil War, President Lincoln authorized the organization of the United States Sanitary Commission with limited powers to supervise the health of the Union Army. State and local chapters were set up and their volunteer members constituted a vast male and female organization to aid the army's regular medical corps. One division of the Commission gathered hospital equipment, bed-clothing, underwear, and food delicacies, even fruits and vegetables, for the soldiers. Another formed a nursing staff and worked close behind the battle lines and in the military hospitals. A third, a smaller group, composed of some of the nation's leading doctors, inspected sanitary conditions in army camps and distributed health pamphlets to soldiers.

CIVIL WAR TO NEW DEAL

Government functions in public health grew steadily during the 1870's, 1880's, 1890's, and during the early decades of the twentieth century. During this time, state, county and city health boards proliferated. Local sanitary codes covered street cleaning, garbage collection, sewage, housing, screening, industrial hygiene, cleanliness in food and drink, filtering and chemical purifying of water supplies, certifying and pasteurizing milk. Vital statistics were better kept. At first state and local health boards were staffed with "political doctors" and inefficient personnel, but through the years administrative and technical competence increased. Local governments assumed more responsibility for the care and hospitalization of the indigent. State governments built and maintained special schools for deaf mutes and for the blind.

The period from around 1875 to around 1920 has been called "the Age of Bacteriology." Revolutionary advances were made in discovering the specific causative agents of communicable diseases and in developing vaccines and antitoxins to immunize against

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them. Local health boards established laboratories to run down the sources of infection and contagion in their communities and to give vaccinations and immunization shots, blood tests, and venereal tests. By the second and third decades of the twentieth century many communities were providing free clinics for administering vaccinations, immunizations, blood tests, and venereal treatments. Many states and even some localities established hospitals for inexpensive or free treatment of tuberculosis.

During the early decades of the twentieth century, public health nursing developed. School children were required to be vaccinated against smallpox; later they were given free eye, ear and dental examinations; and, later still, free general physical examinations. Finally concern about malnutrition in school children led some communities to provide free milk and even free lunches in the schools.

After 1870, the states increasingly and progressively assumed control of the licensing of physicians, raised the standards for practice, and spent larger sums of money on state medical schools.

As late as 1870 the federal government's activities in health were largely limited to restricted cooperation with state officials in administering quarantine regulations at the ports; medical, nursing, and hospital treatment of sick and disabled seamen; medical care of those in the armed services and the federal prisons; and some responsibility for the health of the Indians on the reservations.

FEDERAL EXPANSION

After 1870, federal functions expanded, at first slowly, then more rapidly. In 1870, the Marine Hospital Service was drastically reorganized and its director, Dr. J. M. Woodworth, in effect became the first Surgeon General of the United States. In 1878, a devastating yellow fever epidemic swept up the Mississippi Valley from New Orleans and brought effective pressures for the establishment of a National Board of Health. This functioned from 1879 to 1883 to formulate regulations to prevent the spread of communicable diseases from state to state and to furnish federal inspectors at leading ports to check on state inspection. The Board was allowed to lapse in 1883 for a number of reasons: its inherent administrative defects (the major part of the Board consisted of seven leading physicians living in various parts of the United States and the Board was without centralized or trained staff); the antagonism of state boards of health, particularly that of Louisiana, to the National Board; and the mutual jealousies of the Marine Hospital Service and the medical departments of the Army and the Navy and the National Board. However, in 1893, the federal government finally asserted its authority over port quarantine, and the Marine Hospital Service was enjoined to maintain federal control quarantine stations at American ports.

In 1901, the federal Hygiene Laboratory was established in Washington, to conduct epidemiological investigations and research, and in 1902 it was given the power to standardize and regulate the interstate sale of viruses, serums, toxins and other biological products. In 1906, the Meat Inspection Act provided for federal inspection of all meat destined for interstate commerce, and that same year a Pure Food and Drug Act was passed which placed some restrictions on producers of prepared foods and patent medicines. The administration of these laws was placed in the Department of Agriculture, illustrating the tendency of the federal government at that time to scatter the administration of its public health measures. Under President Taft, the Bureau of Mines was set up, which among other things was to conduct industrial hygiene studies.

THE U.S. PUBLIC HEALTH SERVICE

The United States Public Health Service was established in 1912. This took over the functions of the Marine Hospital Service and most of the government's investigations and research into health matters. It was also given control over interstate sanitation and the spread of communicable diseases from state to state. Under the United States Health Service, the National Leprosarium

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was established in 1917 and the Division of Venereal Diseases in 1918.

In 1912, the federal Children's Bureau was set up in the Department of Labor to act as a clearing house of information about state laws on maternal and child care and on child labor. In 1921, the federal government began a program of grants-in-aid to the states for maternal and child care, and the Children's Bureau was given the administration of this program. Again this illustrated the scattered administration of the federal government's growing activities in health and welfare matters. It was not until the passage of the federal Social Security Act in 1935 that a real beginning was made in coordinating a comprehensive federal health and welfare program. This trend was accelerated in 1939 with the establishment of the Federal Security Agency.

Historically, aside from the federal government's responsibility for the medical treatment and hospitalization of disabled seamen, the entering wedge for direct individual medical help to civilians by the federal government came by way of aid to veterans of the armed services. In 1833, the federal government established a pension system for relief of veterans mentally or physically disabled while in the service. In 1865, the National Home for Disabled Volunteer Soldiers (and sailors) was set up. (By 1930, the National Home had 11 branches—"the old soldiers' homes.") In 1890, federal pensions were extended to all mentally and physically disabled veterans without regard to whether the disability was incurred in the service. In 1904, federal pensions were extended to all veterans over the age of 62, regardless of disability.

In 1917, during World War I, the Bureau of War Risk Insurance was authorized to administer the allotment program for dependent families of members of the armed services; the death and disability compensation program; the life insurance program for service men and women; the rehabilitation and vocational training for veterans; and the medical and surgical treatment of veterans. The Federal Board of Vocational Education was organized to carry into actual execution the program for rehabilitation and vocational training. To the United States Health Service was assigned the active operation of the veterans' hospitals distributed over the country with their large staffs of doctors, nurses, and technicians.

In 1921, the Veterans Bureau was established. This absorbed those functions of the Bureau of War Risk Insurance dealing with veterans, those of the Federal Board of Vocational Education, and those of the United States Health Service with respect to running the veterans' hospitals. The Veterans Administration (1930) in turn set up coordinated veterans' affairs in still more centralized fashion when it took over the functions of the Veterans Bureau, the Bureau of Pensions, and all branches of the National Home for Disabled Volunteer Soldiers.

Since 1917, hundreds of thousands of former service men and women have been treated in veterans' hospitals. This constitutes the nearest thing to "socialized medicine" in the United States. Most patients testify to satisfactory service in these institutions. Most doctors believe treatment has been competent. There are some doctors, once connected with these hospitals and later private practitioners, who insist that the cooperative practice of staff consultation is actually preferable to "the solo practice" of individual doctor and patient. However, there is a widespread belief that the veterans' hospitals represent too limited an experience from which to deduce valid conclusions about the operation of a general system of government medicine in the United States.

After 30 years on the University of Florida faculty, **William G. Carleton** retired in 1961 to devote full time to writing, research and lecturing. He is the author of *The Revolution in American Foreign Policy,* and has written numerous articles on domestic and international politics. He is now engaged in research for a book on certain aspects of the history of American politics, under a grant from the Social Science Research Council.

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Opposition to a national health program in the 1930's grew out of "intangible fears concerning the freedom and status of the physician. The greater the degree of federal involvement, implicit in any large-scale financing of medical services, the less presumably would remain of the traditional entrepreneurial individualism."

The New Deal and National Health

By Roy Lubove

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Shortly before Franklin D. Roosevelt's election to the presidency in 1932, the Committee on the Costs of Medical Care (C.C.M.C.) issued its final report, thus igniting a controversy over the organization and financing of medical services. This intensified over the decade and reached a climax in 1939, when Senator Robert F. Wagner introduced a bill to establish a national health program. The recommendations of the C.C.M.C. majority were vehemently denounced by the American Medical Association, whose *Journal* described them as "incitement to revolution" and the product of the "great foundations, public health officialdom, social theory—even socialism and communism."[1]

Organized in 1927, the C.C.M.C. consisted of approximately 50 physicians, dentists, public health experts, social scientists and representatives of other groups. Its chairman was Dr. Ray Lyman Wilbur, Secretary of the Interior in Hoover's cabinet, and formerly President of the A.M.A. and Dean of the Stanford University Medical School. Neither Lyman's respectable credentials, however, nor the C.C.M.C.'s evidence concerning inequities in the costs and distribution of medical services helped moderate the medical profession's indignation over the two key majority recommendations. The first of these urged the substitution of group practice in community medical centers for the lone physician operating on a fee-for-service basis. Specialization, progress in medical science and technology, wasteful duplication in overhead costs, the growing importance of the para-medical professions, the isolation of many physicians from "helpful contacts" with colleagues and hospitals, and the lack of coordination among general practitioners, specialists and medical institutions were cited. According to the C.C.M.C. majority, these problems necessitated the establishment of

> comprehensive community medical centers, with branches and medical stations where needed, in which the medical professions and the public participate in the provision of, and the payment for, all health and medical care, with the professional aspects of the service under the control of professional personnel.[2]

The C.C.M.C. majority insisted that group payment plans were a necessary accompaniment to the community medical centers. No amount of organizational or administrative rationalization could reduce medical costs sufficiently to insure adequate care for the

[1] "The Committee on the Costs of Medical Care," *Journal of the American Medical Association,* XCIX (December 3, 1932), 1951, 1952.

[2] *Medical Care for the American People. The Final Report of the Committee on the Costs of Medical Care, Adopted October 31, 1932.* Publications of the Committee on the Costs of Medical Care, No. 28 (Chicago, 1932), 109.

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entire population. In emphasizing the need for new financing arrangements to distribute these costs more equitably, the C.C.M.C. demonstrated clearly that the problem lay not in the average medical costs which confronted the entire population or any subgroup, but in the unpredictable incidence of illness and costs.

Frequently cited throughout the 1930's was the C.C.M.C.'s survey of nearly 9,000 white families, revealing not only that average and actual costs diverged radically, but that lower-income groups received "far less" medical care than those with higher incomes. Of the families surveyed whose incomes fell below $1,200 a year, 80 per cent spent less than $60 a year for medical services, or 31 per cent of the total bill for the income bracket; but the 3.5 per cent of the families who paid $250 or more accounted for an equal 31 per cent of the total. Hospital bills were crucial in the determination of medical costs. Although one family in five and one person in 17 required hospitalization, hospitalization accounted for 50 per cent of the total bill.

Complicating the problem of wide discrepancy between average and actual costs was the maldistribution of physicians and medical agencies. In 1929, for example, South Carolina claimed one physician for every 1,431 persons in contrast to California's one for every 571; and South Carolina's one hospital bed for every 749 persons compared unfavorably with Wisconsin's one bed for every 154. Too often, it seemed, the availability of medical care was a function of individual or community ability to pay rather than of need.

In order to minimize inequities in the cost and distribution of medical services, the C.C.M.C. majority recommended the use of group insurance, taxation or some combination of both. Sponsored by consumer organizations, group insurance plans would eliminate the risk of catastrophic costs and encourage a more efficient organization and distribution of medical facilities. In the case of poor rural communities, it might be necessary to establish a system of tax-supported medical care, while tax funds in some communities might have to supplement the insurance payments of low-income families. The state and even the federal government could supply financial aid to communities unable to support comprehensive medical care programs. Some members of the C.C.M.C. majority favored immediate adoption of compulsory insurance, although most preferred to try voluntary plans first.

A CHALLENGE TO TRADITION

In the opinion of the A.M.A. the emphasis of the C.C.M.C. majority on community medical centers and pre-paid insurance plans, with or without tax support, raised the question of "Americanism versus sovietism for the American people." Supporting the traditional system of private practice and fee-for-service, the A.M.A. extolled the "right of the American citizen to pick his own doctor and his own hospital, to pay his own bills with his own money, to be responsible to a doctor who is responsible to him."[3] Only thus could the personal relationship between physician and patient so indispensable to effective medical care be preserved. The reaction of organized medicine (the A.M.A. with its county and state affiliates) to the majority recommendations of the C.C.M.C. foreshadowed the subsequent obstruction of efforts to incorporate health insurance in social security and establish a national program.

This obstructionism arose, in part, from the sincere belief that good medical care depended on free choice of physicians by patients and on the right of the medical profession to determine service standards and procedures for distributing them without interference from government officials or bureaucracies. However, the reluctance of organized medicine to endorse group practice or health insurance and its suspicion of government involvement in medical affairs also reflected an emotional, even irrational response to impersonal forces affecting medicine and American society.

[3] The Report of the Committee on the Costs of Medical Care," *Journal of the American Medical Association,* XCIX (December 10, 1932), 2035.

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As rarely before, the medical profession in the 1930's confronted a challenge to its self-esteem and status. It was surprised and resentful to discover that the American people were becoming increasingly critical of the profession's evaluation of its altruism and achievements, and that its ideals of the family physician and private fee-for-service were under attack as anachronistic. It feared that group practice and government-sponsored insurance programs would ultimately transform the physician into a harrassed, incompetent, salaried bureaucrat akin to the public health official.

> State medicine [is not] attractive to the family doctor. He sees a few brilliant career men who have fought their way to the top, but he believes that most of the rank and file of the lower grades have been lured into the service by the prospect of soup-bone security. The contemplation of the health officer does not inspire him with envy. He would like the salary, but he very seldom desires to become a full-time man in a poorly paid and poorly equipped political operation.[4]

Resistance to compulsory insurance or further government encroachment, in essence, represented a struggle to maintain status, to perpetuate the entrepreneurial individualism of the past and preserve medicine as an island of private enterprise in a world of corporate, centralized organization. The medical profession believed it was engaged in a life-and-death struggle to retain its identity and protect the American people from innovations that would deteriorate standards of medical care.

A serious conflict arose in the 1930's between the medical profession determined to safeguard its entrepreneurial integrity and social reformers who believed that the medical needs of the population necessitated significant changes in the organization and financing of medical services. New Deal health reformers acted on the assumption that the chronic, structural faults of the American medical system exposed by the C.C.M.C.—a wide regional variation in medical and health facilities, the correlation between income and medical care, and generally the availability of medical services as a function of ability to pay rather than need—could be corrected only by means of an intensive national effort. Although the medical profession managed to block any state or federal programs of compulsory health insurance, the era of the New Deal gave birth to the ideal of a national health program and incorporated certain elements in a social security system. During the New Deal, widespread interest in national resource planning to achieve a superior relationship between land and population was matched by an interest in social planning to nurture and conserve human resources.

ORIGINS OF A NATIONAL PLAN

Federal involvement in health and medical care through numerous relief and welfare programs, beginning in 1933, was instrumental in the evolution of a national health plan. These programs accustomed Americans to the use of federal funds for medical purposes, revealed unmet health needs among the population, and affirmed in principle that health was an essential component of tax-supported welfare services. The transition was easy from this principle to the conviction that any permanent social security program should provide for health and medical needs.

The Federal Emergency Relief Administration, as early as June, 1933, authorized use of its funds for medical care and supplies, nursing and emergency dental service. In the two-and-a-half years of its operation, the F.E.R.A. not only helped provide remedial medical services for relief clients, but stimulated interest in health problems, especially in rural areas which lacked physicians as well as medical facilities of all kinds.

On the other hand, the serious limitations of the F.E.R.A. program, arising from a shortage of funds and the supervision of health services by a temporary relief agency, made it clear that a more efficient and amply-financed governmental machinery had to be devised. Many states did not use F.E.R.A. funds for medical care; assistance was restricted to relief clients and did not cover

[4] Nathan B. Van Etten, "The Old Family Doctor—and the New," *Survey Graphic*, XXIII (December, 1934), 594.

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hospital costs; neither dental care nor chronic illnesses received adequate consideration; and the limitation of funds frequently resulted in a "tendency to interpret the program . . . in terms of 'emergency care.' The interpretation often varied with the amount of money available to pay for care. Usually only urgent cases were accepted, and if the funds were at low ebb all but life and death cases were refused."[5]

Like the F.E.R.A., other New Deal relief and welfare agencies played a role in directing attention to health needs and stimulating interest in a more effective, permanent national program. The effort devoted to health and sanitary conditions in Civilian Conservation Corps camps, for example, was acclaimed in public health circles. The Medical Service and Health Section of the Tennessee Valley Authority established employee medical centers at various construction sites, each directed by a medical officer; in addition, the T.V.A. appropriated some funds to improve local health services for the protection of its employees. During its brief existence, the Civil Works Administration, in collaboration with the United States Public Health Service, was active in the control of malaria, spotted fever, and typhus, the sealing of mines and rural sanitation.

Both the Public Works Administration and the Works Projects Administration participated in numerous programs affecting health and sanitary conditions. By 1940, the P.W.A. was responsible for the addition of some 120,000 hospital beds. Sixty-seven per cent of the sewage treatment plants built between 1933 and 1940 were P.W.A. projects. The W.P.A. erected 100 hospitals and improved 1,422 others by June, 1938. This agency also lent skilled and unskilled personnel to health organizations and clinics of all kinds, and W.P.A. employees conducted the National Health Survey of 1935–1936. Directed by the Public Health Service, the survey was the most comprehensive ever attempted. Its findings became the leading factual source for those active in the delineation of a national health program.[6]

F.S.A. HEALTH INSURANCE

The Farm Security Administration was distinctive among New Deal welfare agencies in sponsoring, beginning in 1937, a health insurance plan for low-income farm families. By the end of 1940, the plan affected approximately 400,000 persons in more than 600 counties. The F.S.A. experience illustrates why federal relief agencies were often forced to participate in health and medical care. F.S.A. county supervisors, in close touch with borrower families, reported that defaults were frequently attributable to ill health. Borrowers sold livestock to pay medical bills and inadequate medical care resulted at times in avoidable deaths.

The F.S.A. cooperated with state medical societies in preparing insurance plans. When mutual agreement was reached on general terms, the F.S.A. then worked out detailed arrangements with county or district medical societies. The typical plan involved the pooling of family contributions in a common fund placed in charge of a trustee. Participating physicians, who had agreed upon a uniform fee schedule, were paid from this fund on a pro rata monthly basis. Less frequently, F.S.A. plans included the maintenance of a separate account for each family rather than a pooling of funds, and the employment of salaried physicians by associations of F.S.A. families. For their insurance payments, ranging from $15 to $30 a year, the families received home and office care, emergency surgery and hospitalization, obstetrical and dental services and drugs.

The F.S.A. sponsored other programs for special population groups. In the homestead projects which it supervised, consisting often of isolated clusters of farms, the F.S.A. encouraged group prepayment plans resulting

[5] American Association of Medical Social Workers, "Interim Report of a Study of the Social Aspects of Medical Care Furnished in Several Communities under the Plan of the Federal Emergency Relief Administration, 1935," in Edith Abbott (ed.), *Public Assistance: American Principles and Policies,* I (Chicago, 1940), 464.

[6] On the WPA and PWA see John M. Carmody, "The Federal Works Agency and Public Health," *American Journal of Public Health,* XXX (August, 1940), 887–894.

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in the employment of a physician to make emergency visits and hold clinics at regularly stipulated times. In cooperation with the California Medical Association, State Department of Health, and State Relief Administration, the F.S.A. sponsored a non-profit Agricultural Workers' Health and Medical Association. Established for the benefit of California's large migratory population, the Association organized treatment centers in different parts of the state. Migrants were served either by a local physician in charge of the center or by one he selected from a list of participating doctors. A similar program was established in Arizona. Technically, the migrants were expected to pay for the cost of the treatment at some time, but no one really expected that this would occur.[7]

The F.E.R.A., F.S.A. and other temporary relief agencies performed a useful service in providing, directly or indirectly, for the medical exigencies of their clients. From the viewpoint of national health needs, however, their efforts were hopelessly inadequate. They lacked sufficient funds, direction and coordination. Equally important, their services were categorical rather than general in application, resulting in a conflict between eligibility requirements and need as the determinant of medical care. Passage of the Social Security Act in 1935 signified the true beginning of a national health program and opened a new era in the history of American health and medicine. In the 1930's, the federal government, for the first time, sponsored legislation to establish a comprehensive national health program, financed in part with federal funds, and directed toward the elimination of inequities in the financing and distribution of medical services. The Social Security Act was a pivotal measure which provided a centralized machinery designed to correct some of these inequities, and a nucleus from which a more comprehensive national health program could evolve.

The Committee on Economic Security, on whose report the Social Security Act was based, emphasized that "illness is one of the major causes of economic insecurity which threaten people of small means in good times as in bad."[8] The close relationship between health and security coupled with the inability of a considerable percentage of the population to command adequate medical care for lack of money, justified the incorporation of health provisions in any social security legislation, in the Committee's opinion.

Thus Title V, Part 1 of the Social Security Act authorized an annual appropriation of $3.8 million for maternal and child health services administered through the states by the Children's Bureau. The Title stipulated that the funds would be provided to the states on a matching basis and apportioned as follows: $20,000 for each state which had prepared an approved plan; $1.8 million divided according to the live births in each state in proportion to the total number of live births in the United States; and $980,000 allotted on the basis of financial need. Title V, Part 2, authorized an appropriation of $2.8 million annually to assist states in locating crippled children, and providing them with hospital, medical and after-care services. Also administered by the Children's Bureau, this matching grant-in-aid program alloted $20,000 to each state, and divided the remainder according to the need of each state as determined by the number of crippled children on record.

Title VI of the Social Security Act authorized an annual appropriation of $2 million to the United States Public Health Service for investigation into disease and sanitation problems, and another $8 million to be distributed by the Surgeon-General to assist states and their political subdivisions in the

[7] R. C. Williams, "Development of Medical Care Plans for Low Income Farm Families," *American Journal of Public Health*, XXX (July, 1940), 725–735; Richard Hellman, "The Farmers Try Group Medicine: Rural Public Health Under the Farm Security Administration," *Harper's Magazine*, CLXXXII (December, 1940), 72–80.

[8] *Report to the President of the Committee on Economic Security* (Washington, D.C., 1935), 38. The Committee consisted of Frances Perkins, Secretary of Labor, Chairman; Henry Morgenthau, Jr., Secretary of the Treasury; Homer Cummings, Attorney General; Henry Wallace, Secretary of Agriculture; Harry L. Hopkins, Federal Emergency Relief Administrator. It appointed Edwin E. Witte as Executive Director.

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improvement of public health services. The Surgeon-General was directed to distribute the $8 million according to the population, special health problems and financial needs of the respective states.[9]

IMPLICATIONS OF SOCIAL SECURITY

The implications of the Social Security Act were profound. It established a permanent machinery to distribute federal funds for health and medical purposes, and it took account of special needs and problems in the allocation of these funds. Thus it epitomized the two key premises from which the national health program of the 1930's evolved: 1) that the elimination of inequities, geographical and functional, in the distribution and financing of medical services necessitated national action, and 2) that need rather than ability to pay should determine the availability of medical care and public health services.

Omitted from the Social Security Act, of course, was any provision for health insurance, voluntary or compulsory. The subject had been considered at great length by the Committee on Economic Security, whose relationship with the A.M.A. had been turbulent from the start.[10] Although the Committee offered no recommendations on health insurance in its report to the President in January, 1935, it indicated that research was in progress on a contributory plan which contemplated federal subsidies or grants to states which established insurance programs covering medical care, and cash benefits to compensate for wage losses during illness.

This was enough to arouse the A.M.A., which called the second special session of its House of Delegates in its entire history. Convening in February, 1935, the delegates passed resolutions approving the Committee on Economic Security's recommendations on public health, condemning the administration of maternal and child health by the Children's Bureau, and smiting compulsory insurance. The House of Delegates, however, made one significant departure from the A.M.A.'s previous position on health insurance when it cautiously endorsed voluntary plans controlled by state and county medical societies. Consequently, the A.M.A. could no longer be accused of opposing all substitutes for fee-for-service. Thus internal and external critics were disarmed, and opposition to government-sponsored voluntary or compulsory plans was solidified.

Unwilling to risk the entire Social Security Act by including health insurance, both Roosevelt and the Committee on Economic Security agreed to avoid the subject until Congress had enacted the bill.[11] The Committee subsequently transmitted a report to the President which recommended a federal-state permissive health insurance system including grants to states which established approved plans and disability cash benefits along the lines of unemployment compensation.

No official action was taken on the report, but amendment of the Social Security Act to include health insurance emerged as one of the most prominent social issues of the late 1930's. Indeed, the successful administration of its health titles nurtured the conviction that only a national health program including insurance could insure that the American people received medical care according to their need rather than their ability to pay. Grants-in-aid for maternal and child health, crippled children and public health came at a time when depression retrenchments had seriously undermined public health agencies and the morale of their employees.

Federal assistance helped restore morale and enabled state and local agencies to expand their existing programs or introduce new ones.

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[9] A few other provisions of the Social Security Act had some relation to health and medicine. Title V, Part 3 authorized an annual appropriation of $1,500,000 for child welfare services, and Title V, part 4 authorized appropriations of $841,000 for the first two years and $1,938,000 thereafter for vocational rehabilitation. Federal assistance for this purpose was already in progress under an Act of 1920. Title X of the Social Security Act authorized an appropriation of $3,000,000 and a "sufficient" sum thereafter for aid to the blind.

[10] Edwin E. Witte, *The Development of the Social Security Act* (Madison, Wisconsin, 1963), 173 ff.

[11] *Ibid.*, 187–188.

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IMPROVING PUBLIC HEALTH

Under the auspices of the Social Security Act, the nation experienced one of the most intensive upsurges of public health organization in its history. Ironically, the Committee on Economic Security had not originally contemplated public health grants, but had employed Edgar L. Sydenstricker and I. S. Falk, two expert statisticians and medical economists, to develop principally a health insurance plan. It was Michael M. Davis of the Julius Rosenwald Fund who proposed the health grants which proved to be "throughout the congressional consideration . . . a source of strength for the bill."[12] Following passage of the Social Security Act, the 594 counties in the United States with local health departments under the direction of a full-time medical officer increased to 1,371 by 1939.

Between February, 1936, and June, 1939, federal funds assisted in the training of 5,400 public health workers, including physicians, nurses and engineers. No state had an organized pneumonia control program in 1935, but by 1940, 34 states with Title VI assistance were spending nearly $660,000 for the purpose. Similarly, the three states in 1935 with cancer control programs increased to 16 by 1940; the 15 active in dental hygiene in 1935 increased to 38 by 1940, and the three carrying on industrial hygiene work increased to 31 by 1940. Of the rise in expenditures for local health services from $7.5 million in 1935 to more than $17 million in 1940, approximately 40 per cent was attributable to Title VI funds.[13]

The A.M.A. observed with dismay an increasing pressure for amendment of the Social Security Act to include health insurance as part of an even broader national health program. Its unyielding resistance to any hint of government-sponsored health insurance was understandable; such insurance became a symbol of all those innovations which, in its view, threatened to transform the physician into a salaried employee and shift control of medical affairs from the profession to political and lay bureaucracies. Invariably, organized medicine equated preservation of the physician's status as an independent entrepreneur and freedom of the profession from external interference with continued high standards of medical care. A situation was developing in which organized medicine, already disturbed over the growth of group clinics and increasing federal involvement in medical affairs, would resist any national health program including insurance.

But the laymen and technicians—physicians, public health and social insurance experts, medical economists and sociologists—active in the preparation of a national health program between 1935 and 1938 could not conceive of an effective plan which omitted insurance. The findings of the National Health Survey of 1935–1936 concerning the relationship between health, medical care, and income offered convincing proof in their eyes that a mechanism superior to charity or fee-for-service had to be established. Otherwise, the desired goal of medical care as a function of need rather than ability to pay could not be attained. They hoped that the medical profession would cooperate in the preparation of a plan which served the purpose and simultaneously insured a satisfactory status for the physician and medical profession.

THE NATIONAL HEALTH SURVEY

Covering some 800,000 families, including 2.8 million persons distributed over 83 cities and 23 rural areas in 19 states, the National Health Survey extended from November, 1935, to March, 1936. Once again, as was demonstrated by the C.C.M.C. and even earlier by those who inspired the health insurance movement climaxing around World War I, it seemed that those most in need of medical services were least likely to obtain them for lack of ability to pay. Here was the chronic institutional fault of American medicine, affecting not only the utilization of medical services, but their distribution insofar as economic opportunity exerted an influence.

The National Health Survey's canvass of a

[12] *Ibid.*, 171, 172.

[13] The annual reports of the Social Security Board provide a convenient summary of progress under all the Titles of the Act.

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2.5 million urban population revealed that lower-income groups not only required more medical care than higher-income groups, but received less.

Almost half the lowest-income group were beneficiaries of relief in 1935. These relief families suffered disabling illnesses lasting one week or longer in a 12 month period at a rate 57 per cent higher than families earning incomes of $3,000 or more. Disabling chronic illnesses lasted 63 per cent longer among relief families than among the $3,000-and-over group. Twelve per cent of the families with incomes of $3,000 or more received no medical care for disabling illnesses in comparison to 21 per cent of relief families and a similar percentage for nonrelief families with incomes under $1,000.[14]

It is important to note, moreover, that the Survey took place in 1935, the last year in which F.E.R.A. funds were available for medical care. The evidence accumulated by the C.C.M.C. and National Health Survey proved "that the receipt of medical care was associated with income, the poor, in general, receiving the least service," thus necessitating a national health program which aimed to "destroy the correlation between receipt of health service and income."[15]

A COMPREHENSIVE HEALTH PROGRAM

Following passage of the Social Security Act, the Roosevelt administration demonstrated its continuing support of a national health program by the appointment of an Interdepartmental Committee to Coordinate Health and Welfare Activities. The Interdepartmental Committee, in turn, selected a Technical Committee on Medical Care.[16] The latter assumed the main responsibility for preparing the national health plan presented to the President by the Interdepartmental Committee in February, 1938. In March, the President suggested the convening of a National Health Conference to discuss the proposals. Attended by representatives of farm, labor and other consumer groups, as well as the medical and allied professions, the Conference met for three days in July, 1938, when it received and discussed the Technical Committee's plan for America's first comprehensive national health program.

Depending largely upon the National Health Survey for insight into the nation's health and medical needs, the Technical Committee's first recommendation proposed an enormous increase in social security expenditures for public health and maternal and child health. Pointing out that state health department budgets averaged only 11 cents per capita and that local budgets often came to a few cents per capita, it concluded that an adequate public health program would require additional expenditures of $200 million a year, the federal government contributing half.

Although in 1935 all government expenditures for health and medical services totaled some $520 million, or one-sixth of the national medical bill, the amount spent on general medical care for the sick poor exclusive of hospitals was estimated at only $25 million. This sum, in turn, was inequitably distributed, with some communities spending far more than others in proportion to their medically needy population. To expand tax-supported

[14] "Illness and Medical Care in Relation to Economic Status," Division of Public Health Methods, National Institute of Health, United States Public Health Service, *National Health Survey, 1935–1936,* Preliminary Reports, Sickness and Medical Care Series, Bulletin 2 (Washington, D.C., 1938, rev., 1939), 1–5.

[15] George St. J. Perrott and Dorothy F. Holland, "Health as an Element in Social Security," American Academy of Political and Social Science, *Annals,* CCII (March, 1939), 130, 136.

[16] Since the members of the Interdepartmental and Technical Committees were so prominent in the formulation of a national health program it is worth recording the names. The former consisted of: Josephine Roche, Assistant Secretary of the Treasury, Chairman; Arthur J. Altmeyer, Chairman, Social Security Board; Charles V. McLaughlin, Assistant Secretary of Labor; Milburn L. Wilson, Under Secretary of Agriculture. Appointed by the President in October, 1938 were Thomas Parran, Surgeon General; and Aubrey Williams, Deputy Administrator, Works Progress Administration. George St. J. Perrott served as Secretary; E. L. Bishop as Technical Consultant; and Fred K. Hoehler as Administrative Consultant.

The Technical Committee consisted of; Martha M. Eliot, Children's Bureau, Chairman; I. S. Falk, Social Security Board; Joseph W. Mountin, Public Health Service; George St. J. Perrott, Public Health Service; and Clifford E. Waller, Public Health Service.

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medical services, the Committee recommended additional expenditures ultimately reaching $400 million a year, the federal government again supplying half.

GENERAL MEDICAL CARE

The most controversial of the Committee's recommendations, relating to a "general program of medical care" for the self-supporting population, advocated radical changes in procedures for financing medical costs. Estimating that adequate medical care at minimum fees (exclusive of dentistry, medicines, appliances and community services) would cost about $76 yearly on an individual basis, the Committee calculated that this figure could be reduced to $25, including dentistry, if medical costs were shifted from individuals to groups. It recommended, therefore, that the federal government provide states with financial and technical aid in the development of general medical programs based upon insurance, taxation or some combination of both methods. If federal grants-in-aid did not produce the desired results, a uniform federal payroll tax with tax-offsets comparable to unemployment compensation might be used.

Finally, to cope with the problem of wage loss during illness, the Technical Committee recommended temporary disability insurance analogous to unemployment compensation, supplemented by invalidity insurance administered through the old-age annuity mechanism of the Social Security Act. It estimated that the cost of temporary disability insurance would approximate one per cent of wages and provide benefits up to 50 per cent of wages for 26 weeks.

Early in 1939, the Interdepartmental Committee, following numerous conferences with interested groups, formally transmitted the recommendations to President Roosevelt with one important change. Instead of separate programs for the needy and self-supporting, it proposed a unified approach through tax-supported medical services for all included groups, or contributory insurance supplemented, if necessary, by contributions from tax funds for those unable to meet the full premium. In February, 1939, Senator Wagner introduced his bill "To Establish a National Health Program." It amended Titles V and VI of the Social Security Act to provide greater expenditures for maternal and child health, crippled children and public health, and introduced three new titles authorizing federal grants-in-aid for hospital construction, general medical care programs financed through taxation, insurance or some combination, and temporary disability compensation.

Referred to a Subcommittee of the Senate Committee on Education and Labor, which held extensive hearings during the spring of 1939, the Wagner bill was favorably reported in August. The Subcommittee, however, requested time for further study in order to report an amended bill at the next congressional session. No such bill ever materialized. Preoccupied with foreign affairs, and under fierce attack from the medical profession, the Roosevelt administration allowed the national health program to dwindle to an appropriation of several million dollars for a "National Hospital Act" in 1940.

The A.M.A. was not exclusively responsible for the defeat of the national health program. The Wagner bill was criticized by the American, Protestant and Catholic Hospital Associations on the grounds that it ignored the financial plight of voluntary hospitals, and by spokesmen for the American Dental Association who complained, somewhat inconsistently, that it promised too much and too little. Even its defenders, including organized labor, farm groups and the small, but influential Committee of Physicians for the Improvement of Medical Care, had criticisms to offer.[17] Nonetheless, it seems probable that some version of a national health program would have been enacted had organized medicine cooperated and, indeed, adopted any attitude short of relentless, uncompromising hostility.

The A.M.A.'s initial reaction to the na-

[17] "To Establish a National Health Program." Hearings before a Subcommittee of the Committee on Education and Labor. *United States Senate, 76th Cong., 1st Sess., on S. 1620.* 3 Vols. (Washington, D.C., 1939), *passim.*

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tional health program, a series of resolutions adopted at another special session of the House of Delegates following the National Health Conference, was deceptively encouraging. Not unexpectedly, the delegates registered their opposition to compulsory health insurance, "a complicated, bureaucratic system which has no place in a democratic state." After the Wagner bill was introduced later on, its supporters insisted, rather misleadingly, that the national health program never required compulsory health insurance, but merely provided grants-in-aid for any approved state plan of general medical care financed through insurance, taxation or some combination. Technically this was true, but the A.M.A. was correct in assuming from the beginning that compulsory insurance was the general idea. The A.M.A. at its special session did endorse voluntary hospital insurance, growing in popularity since the early 1930's, and the development by county medical societies of "appropriate means to meet their local requirements."

The fact that the A.M.A. did not deliver a wholesale indictment of the national health program raised hopes that some kind of agreement could be reached between organized medicine and the sponsors of the national health program. The latter, however, did not realize that as far as the A.M.A. was concerned, the limits of compromise were reached at the special session of its House of Delegates. As hearings before the Senate Subcommittee on the Wagner bill revealed, the A.M.A. would only accept a national health program with a federal department of health, with an emphasis upon fuller utilization of existing hospital facilities rather than construction of new ones, with no federal grants for medical care of the indigent except in emergencies and, most important, with no general medical care program which even hinted at compulsory insurance. The A.M.A. not only refused to compromise, but refrained from offering constructive amendments to the Wagner bill.

According to A.M.A. leaders, the Wagner bill was the culmination of a ruthless propaganda drive, even conspiracy, to federalize and bureaucratize the physician, and to impose foreign, un-American systems of medical care and social organization upon a public ignorant of its own best interests.

It would be incorrect to assume, however, that the A.M.A.'s position was dictated solely by the desire to retain a favorable economic advantage for physicians under the fee-for-service system. In several respects, the average physician would have benefited substantially from a national health program. For one thing, the medical profession supplied an enormous amount of free service in clinics, hospitals and elsewhere, a burden from which the Wagner bill promised some relief through compensation from insurance or tax funds. Equally important, the C.C.M.C. had demonstrated that medical incomes were uneven, like medical costs. Although in 1929 the median net income of physicians was $3,800, and the average income, $5,300, one-third of all private practitioners earned net incomes of less than $2,500. Nothing in the Wagner bill suggested that private practice would be abolished or that steadier and higher incomes for the average physician would come at the expense of the more affluent.

In the final analysis, the A.M.A. position on the Wagner bill and its relationship generally to the evolution of a national health program were based less on considerations of economic advantage or, for that matter, the concrete medical needs of the nation, than upon more intangible fears concerning the freedom and status of the physician. The greater the degree of federal involvement, implicit in any large-scale financing of medi-

(*Continued on page 117*)

Roy Lubove is the author of *The Progressives and the Slums: Tenement House Reform in New York City, 1890–1917,* and several articles on housing, planning and social welfare. His book on the emergence of social work as a profession will be published shortly. Currently he is engaged in a study of social insurance in the early twentieth century.

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In the fields of health, education and welfare, "the function of the federal government is mainly one of leadership and stimulation, and over-all action only in specific problems that can only be handled on a nationwide basis."

Health, Education and Welfare: The First Decade

By Marion B. Folsom

Formerly United States Secretary of Health, Education and Welfare, 1955–1958

Although Health, Education, and Welfare, the youngest of the cabinet departments, was only recently established, some of its constituent agencies have a history dating back to the early days of the Republic. In 1785, before the Constitution was adopted, the Congress of the Confederation made grants of public lands to the states for public schools. In 1798, the Fifth Congress established the Marine Hospital Service, the forerunner of the United States Public Health Service. The Federal Office of Education was established in 1867; more recently, the Food and Drug Administration was set up in 1907, and the Children's Bureau in 1912.

These and other agencies were brought together in 1939 to constitute the Federal Security Agency. On April 11, 1953, this agency was given Cabinet status as the Department of Health, Education, and Welfare, to carry out "its constitutional responsibility for promoting the general welfare." The creation of the Department received strong bipartisan support in Congress, by a vote of 291 to 80 in the House, by a voice vote in the Senate.

The following material is quoted from speeches by leaders of the two parties in support of the legislation.

Senator Robert Taft, Republican, of Ohio, declared:

> We have sought for a long time to give to the three agencies affected representation in the Cabinet, the policy-making section of the Government, immediately under the President. These activities of the Federal government are tremendously important to the welfare of the Nation, although the Federal government does not undertake to assume primary direction in the three fields.

Senator Hubert Humphrey, Democrat, of Minnesota, declared:

> . . . the plan meets a long felt need for participation by the Federal government in the services of health, education, and welfare. I concur in the view expressed by the Senator from Ohio (Taft) that the essential function of the proposed Department would be the carrying out of present programs, which are, in the main, state-aid programs, and represent mechanisms for cooperation between the Federal government, state governments, and local institutions and governments in the field of health, education, and welfare.

During its first ten years the Department has made very good progress toward accomplishing its intended mission. In these three fields, health, education, and welfare, which affect the daily lives of almost all the people in the country, the tasks can never be fully accomplished, new problems will al-

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ways arise and many of the old ones will remain indefinitely. There has been a distinct advantage in bringing these activities together in one Department.

The agencies incorporated in the new Department were:

United States Public Health Service
- Bureau of States Services
- Bureau of Medical Services
- National Institutes of Health

Office of Education
Social Security Administration
- Bureau of Old Age and Survivors Insurance
- Bureau of Public Assistance
- Children's Bureau
- Bureau of Federal Credit Unions

Food and Drug Administration
Office of Vocational Education
Saint Elizabeth's Hospital

Before tracing the history of the several agencies during the past ten years, let us first examine briefly what has happened to our people and our economy, as these developments naturally have closely affected the programs of this Department.

CHANGE IN THE NATION

Not only has the total population increased by an unprecedented 30 million persons during the period from July, 1952, to July, 1962, but the composition of the population has shown marked change, with the greater increase occurring in the older age and the school-age population. The number of beneficiaries under the Old Age and Survivorship program has increased from 5 million to 18 million. Elementary and secondary school enrollments are now 46.7 million compared with 30.6 million. College and university enrollments have doubled in ten years to 4.6 million students.

There has also been a decided shift in population from farm to city. While the population in the urban areas has increased by 28 million during the last decade to a total of 125 million, the rural population actually declined from 54 million to 53 million. The problems of health, education and welfare are now concentrated, to a large extent, in the urban-suburban areas.

There has been a rapid growth in the American economy during the past ten years, the gross national product increasing from $365 billion in 1953 to $554 billion in 1962. During this period the appropriations for the Department of Health, Education, and Welfare programs rose from $2 billion to $5 billion. The expenditures under the Old Age and Survivorship program amounted to over $13 billion in 1962 compared with approximately $2 billion in 1952; these expenditures are financed from the special trust fund and not from general revenue funds.

Ninety per cent of the Department's expenditures represent grants to the states, local communities and institutions. This percentage has changed little during this period. There have been significant changes in the nature of the grants, however. There have been substantial increases in the grants for public assistance, particularly for Aid to Dependent Children, with a significant increase in the percentage of the federal share of the welfare payments in all the public assistance fields. These federal payments to the states for the needy and destitute account for the great bulk of the appropriations of the Department, and as these are matching programs, the amount of the federal payments are governed by the expenditures made by the states.

The direct activities within the Department, exclusive of the Old Age and Survivorship Program, account for only about ten per cent of the total expenditures.

With the new responsibilities which Congress has given to the Department—which will be described later—and with the culmination of some of the older programs, particularly Social Security, the staff of the Department has increased from 37,000 in 1954 to approximately 82,000 in 1963. Forty-five per cent of these people are engaged in administering the Old Age, Survivorship and Disability program. Other significant increases in staff occurred in the Medical Research Grant program of the National Institutes of Health, in the Food and Drug Administration, and the Office of Education.

During the ten-year period, Congress enacted more than 120 pieces of legislation af-

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fecting the programs of the Health, Education, and Welfare Department—27 of which were considered major items. Let us now review the changes and developments which occurred in the individual agencies.

PUBLIC HEALTH SERVICE

During this period, the Public Health Service increased its own medical research studies; greatly broadened its support of medical research in medical schools and research institutions all over the country; expanded its training programs for research personnel; aided in financing the construction of research facilities by private non-profit institutions.

A 500-bed Clinical Center was opened at the National Institute of Health in 1953. At the beginning of the period there were five institutes concerned with heart, cancer, neurological diseases and blindness, arthritis and metabolic diseases, and mental health. During the last decade, institutes were added for allergies and infectious diseases, and for dental research. In 1962, Congress approved the creation of two additional institutes, one of general medical sciences and one of child health and human development. Congress in recent years greatly increased the appropriations for medical research. The appropriations for 1962 were in excess of $750 million compared with less than $50 million in 1952.

The effective use of these funds has been made possible by a corresponding expansion in the program of training grants for fellowships and traineeships, which has greatly helped to increase the nation's supply of doctors and other specialized personnel for conducting these research activities. Also in 1956, legislation was enacted providing for grants of $30 million a year for a three-year period for research facilities in private non-profit institutions on a matching basis. This program has since been extended to cover seven years, with total federal expenditures of $210 million. These funds are being more than matched by the institutions themselves.

As a result of all these increased efforts, numerous advances have been made in the prevention and cure of disease in many fields.

Over a billion dollars has been spent during this period under the Hill-Burton program for construction of hospitals, nursing homes, and other health facilities, meeting a vital need in many communities and rural areas. Under the Communities Facilities Act, grants have been made to a number of communities and institutions for demonstration and experimental projects to point the way for improvement in the care and prevention of disease.

A major national effort has also been made in the field of environmental health. Legislation was provided during this period to expand the programs to study and control air and water pollution and radioactivity. A National Library of Medicine was established in 1956 and legislation was enacted the same year to expand greatly the collection of health statistics. This work is now being carried on in a National Center for Health Statistics.

The health care of American Indians and Alaskan Natives was transferred to the Department in 1955. As a result of the expanded program of medical services, there has been a steady improvement in the health of these people, which, however, is still well below the level of the general population.

FOOD AND DRUG ADMINISTRATION

The decade has shown an increased need for adequate protection of the consumer against the rapid increase in the use of new chemicals in agriculture, in new additives for processed foods, in the new drugs, and in the wide diversity of drugs and food products now being offered to the public. The principle of premarketing safety clearance by the government was extended during this period to pesticides and to additives for processed foods, with safety controls being provided in each case. Other improvements have resulted from the legislation on labeling requirements. The 1962 legislation has extended the premarketing clearance principle and has provided for additional controls to insure the safety and effectiveness of the new drugs.

The Citizens Advisory Committee in 1955

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reached the conclusion that the Bureau needed additional staff and better facilities and equipment. During the first few years, appropriations were increased moderately, but in recent years, in view of the number of spectacular developments showing the need for greater protection, appropriations have been considerably increased, with resulting increase in staff budgeted positions rising from 800 in 1955 to 3,000 in 1963. The new headquarters building in Washington is nearing completion and a number of new and improved laboratories have been provided in a number of district offices.

OFFICE OF EDUCATION

More far-reaching developments in the Office of Education occurred during this period of time than in any similar period in its history. The original purpose of the Office was to gather statistics and facts. This has been strengthened by additional legislation and by increased appropriations. The new program of cooperative research was made possible through legislation in 1954. The research programs cover projects in fields such as retention of students, mental retardation, school and college organization and administration, and methods of improved instruction in special fields. The Office disseminates the results of these research projects. Grants-in-aid programs, to assist states in extending public library services to local areas, were provided in 1956 legislation.

The most significant step taken in the field of education in this period, however, was the National Defense Education Act in 1958. This Act authorized more than a billion dollars in federal aid during a four-year period. It contained a number of concrete provisions to help meet some of the shortcomings of our educational system, which had been highlighted by the White House Conference on Education in 1955 and the Committee on Education Beyond the High School in 1957. The programs have proved generally successful and Congress extended the act for three years beyond the agreed expiration date.

Repeated efforts, beginning in 1955 through 1962, were made to obtain legislation for federal aid for school construction and other federal aid programs for the public schools as well as for federal aid to college facilities. To date these efforts have not been successful, but legislation is still pending. Efforts have been made, since 1956, to obtain grants for teaching facilities for medical schools, but with no success.

SOCIAL SECURITY ADMINISTRATION

The most significant development in the Social Security field has been the improvement and expansion of the Old Age and Survivorship Insurance program. Because of the amendments of 1954 and later years, the coverage has been greatly increased so that now almost the entire working population is covered. The benefits have been improved and are more realistic compared with the present wage levels. Disability benefits were added to the insurance program. Retirement age has been lowered from 65 to 62, with a corresponding reduction in retirement benefits, and the amount a worker can earn without losing his benefits has been increased. The system, which reached its twenty-fifth anniversary in 1960, is now approaching maturity. There were 18 million beneficiaries in 1962 under the Old Age Insurance program, over three times the number in 1932. Benefit payments under this program amounted to over $13 billion in 1962. A reserve fund of about $18 billion has been accumulated.

In spite of the great increase in its operations, the administration of the system has been kept on an efficient basis, with an expense ratio of less than 2.5 per cent. A committee was authorized by Congress in 1956 to report on the present methods of financing the program. The following is an excerpt from the unanimous report of this group of outstanding men from financial and insurance fields:

> The Council finds that the present method of financing the old age, survivors, and disability insurance program is sound, practical, and appropriate for this program. It is our judgment, based on the best available cost estimates, that the contribution schedule enacted into law in the last session of Congress makes adequate pro-

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vision for financing the program on a sound actuarial basis.

As the result of the expansion of the Old Age Insurance program, the number of recipients under the Old Age Assistance program has declined from 2.6 million in 1952 to 2.2 million in 1962. This group will probably decline more rapidly in the future as a higher percentage of people reaching retirement age are being covered under the Old Age Insurance system. Public Assistance is now carrying out the role originally intended, that is, to supplement the basic insurance program.

The federal financing share of the Public Assistance program has steadily increased, mainly to help the low-income states; the states have also been encouraged to extend and improve medical care available to Public Assistance recipients. A special program was recently started for elderly people who were "medically indigent."

There has been an expansion in child welfare services during the decade and a new program for research in social security, dealing with some of the fundamental questions in the area of human resources and social welfare, has been inaugurated. In 1963, the welfare activities were separated from the Social Security Administration and set up as a separate agency, Welfare Administration, covering Family Services and the Children's Bureau and other welfare programs.

The most important development in the welfare field has been the increased efforts being directed toward prevention and rehabilitation, rather than simply relief for those in need.

VOCATIONAL REHABILITATION

Legislation in 1954 provided for expansion of the program of vocational rehabilitation. Much progress has been made since that time in rehabilitation of handicapped persons to a productive and satisfying life. The new grants-in-aid system has resulted in increased federal and state funds and expanded services to handicapped persons. The number of persons rehabilitated has increased from 55,800 in 1954 to 102,400 in 1962. About 600 research and demonstration projects have been approved under the program of research and training in the areas such as mental retardation, blindness, speech and hearing problems. The incentive grants program has expanded the establishment or improvement of facilities and workshops. Federal money has also been used to construct 235 rehabilitation facilities, with $48 million in federal funds and $102 million in local funds. The Administration is also working closely with the state rehabilitation agencies in conducting demonstrations of rehabilitation of clients on public welfare. This progress clearly demonstrates the value of cooperative efforts among federal, state, and local agencies in health and welfare activities.

SAINT ELIZABETH'S HOSPITAL

During this period there has been a reversal in the long-term upward trend in the number of patients in the hospital but the turnover has increased considerably. The average number of patients has declined steadily since 1955 and the number of patients on visit or leave status has risen steadily. There has been a marked change in treatment methods and programs during this period. The use of tranquilizer drugs has been shown to be effective and the surgery was discontinued.

A successful employment program for rehabilitated patients has been developed. As the result of the recommendations made by

(*Continued on page 117*)

Marion B. Folsom is a director and former treasurer of the Eastman Kodak Company in Rochester, New York. From 1953 to 1955 he was under secretary of the Treasury. He was a member of the New York State Advisory Council on Unemployment Insurance from 1935 to 1950, and is director of the National Bureau of Economic Research. During the 78th and 79th Congresses, he was staff director of the House of Representatives Special Committee on Postwar Economic Policy and Planning.

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"A public decision must be made, deliberately or by default, on the issue of how much support is to be given the community-based non-profit plans, vis à vis *other types of prepayment organizations." This specialist believes that "the fate of voluntary health insurance . . . may well rest with Blue Cross."*

Voluntary Health Insurance

By Harry J. Becker

Executive Secretary of the Committee on Special Studies, New York Academy of Medicine

Voluntary prepayment for health care did not receive serious and widespread public and professional attention until about a quarter of a century ago. In a few years—by the early 1940's—it had become an established social movement. By the early 1950's, a majority of the population had adopted this new method of financing for at least a part of their health care costs. Today, an estimated 140 million Americans, or about 75 per cent of the population, are covered by some form of health insurance.

The quality of protection which these 140 million Americans are buying varies widely, and the amount of funds budgeted for prepayment of health care, likewise, varies widely from family to family. Hospital care benefits are the most commonly purchased type of protection. Benefits to cover the cost of physician services are, in general, weighted toward surgical care provided in the hospital.

Consumer expenditures for prepaid health care have been rising at a much faster rate than has the number of persons covered; this increase has been of a magnitude of 10 to 12 per cent a year. This increase reflects the rising unit costs of health care as well as a marked year-to-year upward trend in the quality of benefits purchased.

There are today over 1,800 insuring organizations providing health care benefits. Approximately 800 of these are insurance companies; 77 are Blue Cross plans; and 69 are Blue Shield plans. The remaining 800 fall outside these categories, and for this reason have historically been called "independent health insurance plans." The independent plans, as a group, are more significant for their innovations and experimental approaches than they are for the total number of persons they cover; their enrollment represents only about four to five per cent of all covered persons.

With 1,800 insuring organizations competing for the public's prepaid health care dollar, the question of the ultimate efficiency and effectiveness of a competitive atmosphere of such magnitude must be raised. True, this competition makes for experimentation, innovation and refinements, but does it not at the same time make for greater disorder and confusion in voluntary prepayment financing than is practical and in the public interest? It most certainly complicates the task of community planning and coordination, and makes for confusion for both the public and the providers of health care. A large hospital, in a given month, may have financial arrangements with patients involving several hundreds of insuring agencies, and even more hundreds of benefit patterns.

Too often voluntary prepayment for health

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care is thought of as a depression-born development, accelerated by the desire to find an alternative to a government-sponsored health insurance system. This may be true, in part, but it is not so true as commonly supposed. Other factors have played an even greater role in the development of the voluntary prepayment idea than the fear that "if we don't do it, government will." Underlying economic and social pressures, rising standards of health care coupled with a steep increase in the cost of health services, and the growing consumer demand for health care were all important factors in the rapid growth of voluntary prepayment. Likewise, the development of collectively bargained employee health benefit plans was a contributing factor the impetus of which must not be overlooked.

EARLY PLANS

First, prepaid health care was not a new idea that emerged in this mid-century—as so many persons believe. The first prepaid hospital-care program in the United States was established more than 150 years ago. Under an Act of Congress in 1798, the Customs Collector was required to collect 20 cents a month as a deduction from the wages of every American seaman. The money was used "to provide for the temporary relief and maintenance of sick or disabled seamen. . . ."

About one hundred years after this first prepaid health care plan was established, the idea of prepaid care appeared again, this time on a more significant scale. The mining, lumber, and railroad industries, pushing their operations in the latter part of the nineteenth century into isolated areas which lacked hospital and medical facilities, instituted various prepayment methods for financing needed facilities and services. The cost of these prepaid services was financed by employers and employees, with the employees' portion obtained through payroll deduction. These early plans were administered by employers or by joint employee-management committees. Some of these early prepayment plans are still in existence.

The development of prepayment arrangements for health benefits have through the years directly reflected the social and economic problems of particular periods. In isolated areas, where new industries brought population migration, the problem was money to build facilities and to assure physicians a reasonable income. At the same time, in the cities, the problem was more one of wage-loss replacement during periods of unemployment due to illness. The gainfully employed, working for wages, found paying for health care less of a problem than income maintenance during periods of illness. As late as the turn of this century, medical care was relatively inexpensive and was provided for the most part by a single physician in the doctor's office or in the patient's home. Hospital care, the more costly segment of health care, was at that time largely limited to the indigent, and was custodial in character.

The voluntary prepayment plans in existence today must be viewed from the historical background out of which they emerged. At the beginning of this century the new role of the hospital began to take shape, as science required more than the services available from a physician equipped with the symbolic "little black bag." Medical science was growing more complex and more costly. The hospital-based services began to grow in scope and importance—and in complexity. Hospitals began to realize that the cost of care could not be financed by the sick paying for care at the time of illness.

In 1912, for example, the Rockford Association was established to provide the community with prepaid hospital care benefits. It was open to any resident of the community, and the benefits included six weeks of hospital care and operating-room fees. In Grinnell, Iowa, in 1921, a hospital plan was developed which covered room, board, and nursing care, up to a period of three weeks. A few years later, in Brattleboro, Vermont, the Thompson Benefit Association was organized; it provided hospitalization benefits up to a maximum of $300, including surgeon's fees. The best known plan established in the 1920's was that at Baylor University Hospital in Dallas, Texas, which, in 1929, covered

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1,500 schoolteachers with prepaid hospital care, at a cost of $6.00 a year per schoolteacher.

Through the early 1930's it was the hospitals, in particular, which took the initiative in the establishment of prepayment plans. At first these plans were not looked upon as a form of insurance "business," but rather as a group contract for the sale of services by the hospital to subscribing members. The first stage was sponsorship of prepayment plans by individual hospitals. Quickly, it became apparent that all the hospitals in a community might join forces and sponsor a single prepayment plan. This resulted in the need to formalize the structure of the prepayment plans, and bring them under the supervision of state regulatory authorities. Enabling laws were enacted to bring these prepayment plans under state supervision without subjecting them to requirements of the existing laws pertaining to the business of insurance.

New York State took the lead in providing the legal bases for prepayment plans when civic leaders and hospital administrators and trustees cooperated in the preparation of an enabling act to permit the establishment of non-profit hospital-service corporations. The New York Legislature enacted the bill, which became effective May 16, 1934, and a year later the Blue Cross Plan of New York City began operation.

THE BLUE CROSS MOVEMENT

The initial Blue Cross pattern of organization spread rapidly, and by 1939, 48 similar plans had been established under laws enacted in 27 states. Thus began the Blue Cross movement.

The growth of Blue Cross has been a spectacular phenomenon. Enrollment was 4.4 million in 1940. In the following decade, it jumped to 33.4 million. Since 1950, the number of persons covered by Blue Cross has continued to grow, though at a somewhat slower rate. Today, Blue Cross enrollment is about 58 million. It should be noted that one reason the rate of enrollment growth for Blue Cross has not been so great in recent years is the competition of coverage offered by the insurance companies.

The distinguishing characteristics of Blue Cross service today are essentially the same as those around which the first plans were developed. Each plan is an autonomous, non-profit organization, under the policy direction of a board of trustees who are broadly representative of various community and civic interest groups. Hospital representatives generally predominate on the boards, but do not necessarily constitute voting majorities. There is today a marked trend toward bringing onto the boards people who are consumer-oriented rather than representative of the provider of services.

Most plans have agreements with the hospitals in the geographical areas they serve, under which the hospitals agree to provide the benefits made available to its members by Blue Cross. The hospitals are paid directly by Blue Cross, in accordance with an agreed upon payment formula. Most plans pay hospitals a negotiated rate that is, in practice, different from the schedule of rates customarily charged to the general public. These rate agreements with the hospitals enable Blue Cross to translate the benefits available into terms of "services covered," rather than in terms of dollar indemnification for costs incurred by individual insured patients.

Blue Cross is under increasing pressure, from many sources, to fill a number of roles that might otherwise have to be taken on by public agencies. For example, the fact that Blue Cross is a community-based non-profit prepayment plan and covers more people than any other single organization means that the major impact of public anxiety about such problems as rising costs of care are directed to it.

Increasingly Blue Cross finds itself being asked by the consumers to initiate a variety of measures that will help curb the rise in costs of prepaid protection. These measures include the establishment of community restraints to discourage the building of unneeded hospital beds, and provisions to require that participating hospitals establish utilization committees to reduce the number

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of unnecessary hospital admissions and overlong hospital stays.

There are many persons who believe that government intervention in prepaid hospital care cannot be avoided unless Blue Cross performs those community planning, coordinating, and policing functions, which may help retard the rate of increase in costs of care, and, at the same time, may raise the standards of hospital care. Assumption of these functions means that Blue Cross is tending to become more than a fiscal agent for hospitals and the public—they place on it a public service responsibility which its insurance company competitors are not being asked to perform and which in most cases they could not perform because they do not have either the rapport with the hospitals or the weight in the community possessed by Blue Cross.

In its competitive struggle with the insurance industry, Blue Cross has many problems which it cannot solve by itself. The fate of voluntary health insurance, however, may well rest with Blue Cross. If Blue Cross should fail in its primary public purpose because of competitive pressures from the insurance industry, on one side, and consumer pressures to function as a quasi-public agency, on the other side, there would undoubtedly arise a strong public demand for government action. A public decision must be made, deliberately or by default, on the issue of how much support is to be given the community-based non-profit plans, *vis-à-vis* other types of prepayment organizations. This question needs more public debate and discussion.

BLUE SHIELD PLANS

Blue Shield, the companion organization to Blue Cross, is to medical and surgical benefits what Blue Cross is to hospital benefits. The genesis and growth of Blue Shield followed somewhat the same path as that of Blue Cross—but with some significant differences. The threat of government health insurance was a greater impetus in the development of Blue Shield than it was in the case of Blue Cross. Blue Shield is physician-sponsored, non-profit, and has, like Blue Cross, tried to differentiate itself from insurance company practices and philosophy.

Interestingly enough, the first Blue Shield-type plans had their beginnings in the Northwest, about ten years prior to Blue Cross' birth, in the Middle West and the South. These plans, however, did not enter a period of rapid growth until Blue Cross' development was well under way. Blue Shield's growth was most marked during the post-World War II years, when the medical profession was most concerned with programs to offset federal and state proposals for government health insurance.

The first Blue Shield plans provided a broad spectrum of benefits to cover the costs of the physician's services in the office, at home, and in the hospital. These plans were forced to abandon the intent of comprehensive benefits because of high utilization and the resultant high costs of protection afforded. This resulted in the development of Blue Shield plans providing benefits only for the more costly medical and surgical procedures. Primarily, they became surgical plans.

Today, Blue Shield still gives primary attention to in-hospital provided physicians' services. In the past few years, however, competition from the insurance industry has pushed Blue Shield into providing some types of benefits for services provided on an ambulatory basis.

Blue Shield benefits and rates are determined on a local level, "to fit local needs and conditions." In general, Blue Shield contracts provide partial payments for physicians' services. However, many Blue Shield plans have agreements with physicians that the benefit allowances provided will cover the full costs of services for persons with annual incomes under a given amount. Blue Shield enrollment at the present time is a little over 50 million persons.

The insurance companies came rather slowly to the provision of coverage for hospital and medical care. Since the turn of the century, they explored, and provided, benefits for wage-loss resulting from sickness and accidents. Prior to 1930, some insurance companies did sell surgical- and hospital-

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expense insurance, but it was not until after Blue Cross and Blue Shield began to demonstrate the broad public demand for health insurance that they moved into this area of insurance coverage on a serious and aggressive basis.

INSURANCE COMPANY BENEFITS

The enrollment lead of Blue Cross and Blue Shield over the insurance companies in number of persons covered was maintained until about 1950. Since then the rate of enrollment growth for the insurance companies has exceeded that of Blue Cross and Blue Shield. Today the insurance companies cover some 81 million people for hospital benefits and about 79 million for surgical expense benefits. Traditionally, insurance company benefits have been provided as cash indemnity which is paid to the covered individual, unless assigned by him to the provider of services—the doctor or the hospital. The services for which indemnity is provided are essentially the same as those made available by Blue Cross and Blue Shield. The customary practice is to provide a dollar allowance for each hospital day and a lump sum for "extras." Doctor service benefits are usually expressed as "fee allowances" for given procedures, or for home and office calls.

In 1949, the insurance industry made a major benefit break-through with the introduction of the "major medical" benefit concept. There are many variations in practice within this basic benefit scheme. However, the basic principle is the provision of coverage of a stated per cent of all bills for health care that may be incurred, after the insured person pays a given dollar deductible. The deductible, for example, might be $50 and the balance covered by insurance 75 per cent of total expenses incurred. Thus, a surgical bill of $550 would cost the patient $175. There is a maximum benefit payable which is commonly $5,000 to $10,000, or may be more. Under this benefit plan all charges incurred for a given illness or for a given period of time, such as a year, can be grouped and covered by the insurance company up to the maximum limit, subject to the insured person's payment of the deductible and the coinsurance amount.

This provides a measure of protection for the full spectrum of health services, and eliminates the indemnity allowances for separate items of service. It also provides for services rendered before and after hospitalization or rendered under circumstances which do not require hospitalization: this is the fastest-growing type of health insurance; more than 35 million Americans now have some form of major medical coverage.

Most "major medical" types of health insurance are sold by insurance companies. However, in the past few years Blue Cross and Blue Shield have been developing competitive benefit programs. The "major medical" benefit pattern is incompatible with the "service" benefit utilized by Blue Cross and many of the Blue Shield plans. At the same time, it should be noted that this new benefit formula breaks away from the fragmentation of benefits which occurs when benefits are rendered as allowances or coverage for given items of medical or hospital service.

INDEPENDENT PLANS

Blue Cross and Blue Shield and the insurance companies cover approximately 96 per cent of all persons with health insurance protection. There are about 800 other insuring organizations that cover the remaining 4 per cent of the insured population. These plans are commonly referred to as the "independents." They are difficult to classify as they include a number of types of organizations, which provide prepaid benefits or services in a myriad of forms, which do not fall into the Blue Cross, Blue Shield, or insurance company categories of coverage.

Nevertheless, these plans are far more significant than the small number of persons they cover, in relation to the total number of Americans with health insurance. They are significant because it is in this group of plans that the experimental programs are to be found. Many of the innovations these plans have made are having a very considerable impact on public and professional thinking with respect to future directions in both the financ-

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ing and organization of health services. The largest and potentially most significant groups of plans in the "independent" categories are those that have experimented with bringing physicians together in group practices, and have gone outside of the fee-for-service method of remunerating the physician for his labors.

The plans which have developed variations of these two central ideas are too numerous to describe in detail, or even to list here. The broad outlines of what they are doing should, nevertheless, be noted, and given careful study by persons concerned with how to provide comprehensive health services of high quality at a minimum cost to the consumer. These prepayment plans offer great promise for study of possible new approaches, which might be applicable, to a greater or lesser degree, to the mainstream of health care financing and organization of services.

Considered as prototypes for the future, the group practice plans have brought together all the specialized medical services needed for a comprehensive health service. The family physician is the central figure in diagnosis and treatment of disease but around him, within the group, he has at his disposal all the specialized medical and paramedical personnel whose services may be required by his patients. Laboratories, X-ray and other services are shared by the group of physicians who are working together as an organized unit. Because of the close cooperation necessary for group practice, many observers feel that this mode of providing services offers a more efficient and economical use of medically-trained people than any other.

When the factor of organization is introduced, standards of care can be formulated, jointly, by the physicians in the group, and the observations and conclusions of each individual physician, with regard to the patients he sees, can be readily shared with his colleagues.

A variety of methods have been experimented with in group practice to eliminate the fee-for-service method of payment. Salary has been the method of choice in some instances, and in others salary has been combined with partnership arrangements in which the participating physicians divide the income of the group, as would the partners in any other form of business. Under plans such as these, the group receives a monthly payment from each person who has chosen the particular group's services as the source of his or her medical care. In return for this monthly premium, he or she may receive whatever preventive, diagnostic and therapeutic services may be required.

General conclusions on the strength of group practice plans which pay their physicians on other than fee-for-service bases are hazardous because of the wide range of types of programs currently available. Supporters of these plans argue, however, that they can offer complete medical care—the full spectrum of medical health services—at a cost that is less than that for more traditional patterns of organization and methods of payment. They also argue that standards of care can be maintained at higher levels, and that illness can be detected and treated earlier in its course of development—thus reducing the incidence of prolonged and costly hospitalization—through group practice.

There is much that needs to be learned about the most economical ways to approach the problem of financing and organizing health care under prepayment arrangements. The problems which confront us on these

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"The principle of social security is that workers contribute during their working years . . . to build up rights to benefits during periods when work income is not generally available." This specialist points out that "under the social security approach, the individual would . . . receive hospital insurance protection in old age—a long step toward the prevention of dependency."

Medical Care for the Aged

By Wilbur J. Cohen
Assistant Secretary, Department of Health, Education and Welfare

Older people experience serious and costly illness much more frequently than younger people, and hospitalization is a frequent occurrence among them. The aged have, on the average, two or three spells of illness requiring hospitalization after 65. A couple, on the average, would experience five such illnesses. Medical expenses for aged people who are hospitalized in a year are about five times greater than the medical bills of aged people who are not hospitalized, and hospital costs account for the major portion of the difference. Yet the financial resources of the aged are generally lower than the resources of younger people. A great majority probably can get through the first illness after retirement by using up some of their savings. Further illness, though, is increasingly troublesome financially. As they get older, more and more of the aged exhaust their savings, cash in their life insurance, sell their homes, become dependent upon their children, or get public assistance. These are the basic facts underlying current proposals to provide hospital insurance for the aged under social security.

Social security cash benefits go a long way in helping to meet the day-to-day living expenses of aged people, but they cannot be expected to meet the high costs an older person faces when he is sent to the hospital. Despite the provision of social security cash benefits and other measures that the individual may have taken to protect himself in old age, costly illness can in many cases force normally self-sufficient people to depend on private or public charity. The remedy proposed is hospital insurance for persons 65 and over, financed, as social security is financed, through the collection of contributions from employees, employers, and the self-employed. Under the social security approach, the individual would make contributions during his working years and receive hospital insurance protection in old age—a long step toward the prevention of dependency.

ILLNESS AND FINANCE

Here are a few figures on illness among the aged which suggest the dimensions of the problem they have in meeting health costs. Of the 16 million persons aged 65 and over in 1960, 12 million suffered from one or more chronic illnesses, according to the National Health Survey. Some 28 per cent of the aged suffer from heart disease or high blood pressure. Older people are sick in bed for an average of 14 days a year—even if those who die before the year is out are not counted. On the average, the aged use three times as much care in short-term hospitals as do younger people. The elderly make up 90 per cent of the people in nursing homes.

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What financial resources do aged persons have from which to pay for expensive health care? Every reputable study is in agreement that the financial situation of the aged is singularly poor. The retired aged are least poorly off, naturally, at the time of retirement; in the following years their situation deteriorates as they use up their assets.

The following table from the 1960 census shows how the income of men varies with age. It should be remembered that the income of the man must in many cases also support his wife.

Age	*Median Annual Income of Men, 1959*
25–34	$4,823
35–44	5,465
45–54	5,097
55–64	4,380
65–74	2,024
75 and over	1,229

Aged couples are generally better off than the nonmarried aged, the majority of whom are widows. Among people 65 and over, two-member families had a median annual income of $2,530 while people living alone or as roomers had a median annual income of $1,053, according to census data. Undue emphasis on aged couples tends to obscure the over-all financial situation of the aged, since about half of the aged are nonmarried. The median annual income of the nonmarried aged is less than half the median income of aged couples, but rent, telephone, and even food cost substantially more for a single person than for each member of a couple.

What about assets? In answering this question we must distinguish between assets that are available for use in an emergency, or even for ordinary living expenses, and those reserved for a specific purpose. It is not unreasonable to expect older people to draw upon liquid assets—savings accounts, for example, or savings bonds—as need arises, but it is unreasonable to expect them to sell homes they have lived in for many years, or to cash in life insurance intended to pay their burial expenses, in order to meet medical care costs.

It is very significant, then, that one-third of the aged family units have less than $100 in liquid assets, according to the 1962 Survey of Consumer Finances conducted by the Survey Research Center of the University of Michigan. And, of course, low assets and low income go together; of the aged family units which had incomes of less than $2,000 in 1961, two-fifths had practically no assets. In fact, about two-fifths of all aged family units have total assets of less than $5,000 including their homes.

Is the status of the aged improving? A study by Robert Lampman for the Joint Economic Committee[1] indicates that during the decade 1947 to 1957, despite a great increase in income for the population as a whole, there was virtually no decline in the number of low-income persons among the aged and by many criteria the aged became relatively worse off. And this happened despite a tremendous growth in the proportion of the aged who were eligible for social security—from 21 per cent in 1947 to 60 per cent in 1957. In explaining his finding that the aged remain badly off, Lampman refers to the income of the aged as "immune to economic growth" even though economic growth is the chief element in improving the financial status of the nation as a whole.

Sometimes it is suggested that the children of aged persons can help pay their parents' medical expenses, so that the low income and assets of the aged are not really significant. Of course, not all aged people have sons and daughters to help them. In other instances a young couple may be unfortunate enough to be the sole resource of four aged, ill parents. Often the sons and daughters of aged persons have children of their own to support. And it is becoming increasingly common for the children of aged parents to be aged themselves.

PRIVATE HEALTH INSURANCE

Because of the remarkable strides made by private health insurance in recent years, some people have suggested that private insurance

[1] Study Paper No. 12, *The Low Income Population and Economic Growth.*

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is a solution to the problem of the high health costs of the aged. The aged, however, have not fared nearly so well as younger people in obtaining health insurance. Today about one-half of the elderly population have no health insurance protection at all. The aged who have insurance tend to be persons who are still working and those who have higher incomes or who are in better health.

The problem is that the aged are poor insurance risks because of their above-average health costs, yet their incomes are below average and they cannot generally afford the high premiums that are required to pay for their own protection.

To deal with the problem of the poor insurance risk—and specifically the problem of the aged—Blue Cross has for years had as one of its principles that the same rate should be charged each enrollee regardless of age, sex or other difference. Under this "community rating" principle, the theory was that premiums for the young would be increased by, for example, 20 per cent in order to cut premiums for the aged to 40 per cent of the cost of insuring them.

The principle of community rating has become increasingly difficult for Blue Cross to sustain. Competition from commercial insurers, who did not expect the younger groups to subsidize the aged, has virtually forced Blue Cross to abandon its community rating approach. Its retreat took two forms: enrollment of the aged was restricted by various means; and special policies with substantially higher premiums or lower benefits were offered for the aged.

The latest step in this retreat from community rating was the highly publicized recent offering by most Blue Cross organizations of new nongroup plans for the aged. (Most of the aged, not being employed, must subscribe on a nongroup basis.) These special Blue Cross plans generally have premiums that are high, even though many have waiting periods for pre-existing conditions and impose relatively strict limitations on some of the benefits covered. There are some 76 Blue Cross plans in the United States; 73 have offered nongroup insurance to the aged. Of the 73, 32 have premiums of over $100 a year (exclusive of physicians' coverage) per person and 15 that offer only Blue Cross-Blue Shield combination plans have premiums of over $125 per person a year. Even the $100 per person premiums amount to 10 per cent or more of the median income of the nonmarried aged, and almost 10 per cent of median income for couples, without covering physicians' services or drugs outside of hospitals, or many other medical costs.

The commercial insurance companies, too, have offered policies for the aged. Of the 4.75 million aged covered by commercial plans, some 2.5 million hold policies sold by either of two companies. The popular policy of one of these companies provides a room-and-board allowance of $10 per day for a maximum of 31 days. (This compares with an average daily charge of $18.30 for semi-private—two bed—accommodations in 1961, as reported by the American Hospital Association.) The policy also provides up to $100 for other hospital expenses and up to $200, according to a schedule, for surgery. The premium is $78 a year. In 1961, this company paid out in benefits (including claims adjustment expenses) 49 per cent of premiums for its hospital and medical expense policies.

The second of these best-selling policies for the aged provides somewhat greater, but still inadequate, benefits for an annual premium of $102. The 1961 benefits paid (including claims adjustment expenses) by the company offering this policy were 67 per cent of premiums for its hospital and medical expense policies.

Apparently the deficiencies of the various nongroup commercial policies for the aged have been recognized by the insurance industry. In three states—Connecticut, Massachusetts, and New York—commercial insurers have given up competition and, in some instances, profit to introduce, cooperatively, new state-wide plans for the aged. The plans have a basic portion and a major medical portion, which in combination sell for $228 a year in New York, $210 a year in Massachusetts, and $204 a year in Con-

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necticut—premiums which amount to some 20 per cent of the median income of unmarried aged persons, even though benefit costs are kept down through the exclusion of pre-existing conditions, deductibles, coinsurance, and other limitations. In Connecticut, the plan has taken a fairly substantial loss—over half a million dollars in the first 15 months of the plan, or some 15 per cent of the premiums collected. And this occurred during the period when all the subscribers were subject to a 9-month waiting period on pre-existing conditions.

In all these private insurance plans for the aged there are problems for which no solution is in sight. First, the aged person ordinarily has to pay premiums for private insurance out of current income. In contrast, the social security approach provides a practical method of collecting contributions during the person's working years and providing up-to-date protection in retirement.

Second, few of the aged have an employer contribution made towards their health insurance costs. The only ones for whom an employer payment is practical, even over the long run, are recipients of private pensions, and only the larger employers can establish suitable pension plans. The self-employed, farm workers, domestics, employees of small retail and service establishments are all practically beyond the possibility of coverage under such pension arrangements. Many employees who work for a time in establishments that have pension plans will not meet the requirement of long service, lasting until retirement, that is necessary to qualify for a pension under many plans. A widow generally does not get a pension based on her husband's work. Employer pension arrangements are clearly no solution to the problem.

Third, a continuing problem for private insurance plans is that they get out of date because of rising medical costs. The best plan will be inadequate if 20 years after it is issued medical costs have doubled and the policy holder therefore needs twice as much protection as the policy initially provided. In contrast, social security hospital insurance could be kept up-to-date by reason of the method of financing these benefits, as discussed further on.

INCOME TAX PROVISION

Some people have proposed liberalized income tax provisions as a solution to the problem of the high costs of the aged. But this can hardly be a solution when about 80 per cent of the aged have so little income that they pay no income tax. The aged who benefit from present medical expense deduction provisions are those with above-average income. Medical expense deductions were taken on only 1.8 million tax returns filed for 1960 where at least one taxpayer in the family was aged 65 or over.[2] The less than a million aged who had $5,000 or more in income and who took medical deductions are only 5 per cent of the total aged, yet they not only took two-thirds of the medical deductions of the aged but got far more than two-thirds of the tax advantage. The total cost to the federal government of the medical deductions for the aged is some quarter of a billion dollars, and most of it goes to the highest-income aged.

PUBLIC ASSISTANCE FOR MEDICAL CARE

Some people have argued that public assistance programs can effectively deal with the problem of high health costs in old age. Let us consider what these programs provide.

To meet some of the medical cost problems of the worst-off of the aged, over $600 million was expended during 1962 under the federal-state assistance programs. Of this total some 60 per cent was spent for people on the old-age assistance rolls. A further proportion—perhaps as much as an additional 15 per cent—of the expenditure was made for people who met the means test under the old-age assistance program (O.A.A.) but were aided under medical assistance to the aged (M.A.A.), popularly known as the Kerr-Mills program, which provides aid for aged persons not getting old-age assistance but whose income and resources are insufficient to meet

[2] Internal Revenue Service, U.S. Treasury Department, *Statistics of Income 1960, Individual Income Tax Returns*, p. 93.

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the cost of medical services. (The reasons why some people who meet the O.A.A. means test get assistance under M.A.A. are that some states get more favorable federal financing under M.A.A. than under O.A.A. and that some states with strict residence requirements for O.A.A. provide some new residents with M.A.A.) New York state estimates that 58 per cent of those who have benefited from M.A.A. in that state meet the O.A.A. means test. New York paid some 40 per cent of all M.A.A. benefits in 196.

These state tests of total indigency are very severe. Not only do they require the individual to prove his own destitution, but generally his family also must meet a test of poverty. The applicant must prove to the satisfaction of the assistance agency that he is almost totally without assets and income. New York state finds a person not indigent if he has a reserve of anything over $250. If he has a home, New York places a lien on it and arranges a forced sale upon his death.

Monthly cash payments under O.A.A. average $60 per month for the United States; medical payments average $15 per month per recipient. New York's corresponding averages are about $66 and $16 a month, respectively; Mississippi, the state paying least, pays $33 and $1 a month on the average. Mississippi provides only hospital care and nursing home care; hospital coverage is limited to 20 days care a year for acute conditions, and payments are limited to a maximum of $15 a day. The state pays no more than $50 a month towards nursing home care. Many states are not much more liberal than Mississippi.

Eligibility requirements under medical assistance for the aged may be more liberal than the requirements the state uses for old-age assistance but even so they are often strict. Benefits are often severely limited. In Kentucky and Tennessee hospital care is limited to 10 days; Oklahoma covers life- or sight-endangering conditions only, and so forth. It is clear that, while some 2.5 million aged persons are getting public assistance, the strict tests of need keep many very poor persons off the rolls, and that even when they qualify their needs may be far from fully met.

It is interesting to note that the federal government contributes almost equal amounts in different forms to assist two groups among the aged to meet their medical expenses: (1) income tax deductions for medical expenses to 5 per cent of the aged in the highest income group, and (2) public assistance matching grants for 15 per cent of the aged in the lowest brackets.

DOING WITHOUT ADEQUATE CARE

The primary purpose of the proposed hospital insurance program for the aged is to make serious illness in old age less of a financial catastrophe, but the insurance program will also result in the provision of adequate care to some now doing without it. There are many indications that people with higher income spend more on medical care than those with lower income, even though ill health and low income generally go together.

The National Health Survey reveals substantially less than average health-insurance ownership among the low income group, and there is evidence that people with health insurance are more likely to seek medical care. A study conducted by the Health Information Foundation concluded,

> The public's regular doctors . . . indicate that possessing insurance affects their patients' willingness to accept surgery, diagnostic procedures and the like, and that in this sense possessing insurance affects the amount of medical care that people are likely to get. These doctors are inclined to believe that possessing insurance results in better health.[3]

The Florida Department of Public Welfare recently studied unmet needs for medical care among recipients of O.A.A. in that state. Margaret Jacks, Supervisor of Welfare Services of that department, reported that "there are literally thousands of older people in this State and in other States who are going without medical care" and that the prime factors involved "are a lack of sufficient income for

[3] *Health Information Foundation, Public Attitudes Toward Health Insurance* (Research Series No. 5) 1958, p. 18.

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transportation . . . a lack of income with which to pay for medical care, the patient's embarrassment and unwillingness to ask for medical care when he knows that he cannot pay for this care, and his actual fear of having a complete medical evaluation because it may require even further expenditures for medical care which he is not in a position to purchase."[4]

State studies for the White House Conference on Aging[5] contain innumerable findings of unmet needs both for assistance recipients and for the middle-income aged. Here are a few quotations from these studies:

Massachusetts: A large portion of older chronically ill handicapped persons are in nursing homes or county hospitals where the care often is exclusively custodial. As a result many of these patients deteriorate physically and mentally to the point of almost total disability and complete dependence on others for their care. Such deterioration can be prevented if the broad range of rehabilitation services are made available.

Michigan: . . . the rates paid for public care patients in most areas are totally inadequate to provide quality care.

Texas: . . . it seems accurate to say that Texas is rehabilitating about one-sixth of the number of persons who are disabled each year, not touching the vast backlog. . . . lack of funds has caused the management (of the Texas Rehabilitation Center) to operate at only 55 beds or half of capacity . . . there is little brightness in the picture for the aged adult. . . .

Finally, since nursing homes specialize in looking after older people, their condition is pertinent to the question of whether aged people do without adequate care. Over-all, 40 per cent of nursing home beds are reported by state agencies to be in institutions where there are fire or health hazards, and half the so-called skilled nursing homes do not have full-time registered nurses on their staffs.

The principle of social security is that workers contribute during their working years, when they are best able to make the insurance contributions, to build up rights to benefits during periods when work income is not generally available. If hospital insurance for the aged were provided under social security the workers' payments would be spread over the 40 years or so of their working lifetimes and would be matched by payments by their employers, so that only modest employee payments would be required.

INSURANCE UNDER SOCIAL SECURITY

Because of the practically universal coverage of social security, the problems of adverse selection that plague private health insurance, and that require exclusion of preexisting conditions and similar restrictions do not exist for social security; and it can use the advantages of group coverage to keep administrative expenses to a minimum.

One very important advantage is that as earnings rise and the social security contribution rate is applied to up-to-date earning levels, income to the fund also will rise so that hospital benefits can keep up with the times. This characteristic of social security makes it, for this purpose, far superior to private insurance, which can offer only guaranteed renewability of its policies. This is of little help when the benefits have been fixed a quarter of a century previously.

Over the years, under the social security system, benefits have been increased as prices and wages have risen, and the program has been improved in other ways as the need has

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Wilbur J. Cohen was Technical Adviser to the Commission for Social Security in charge of program development and legislative coordination work with Congress from 1935 to 1952. He served as director of the Division of Research and Statistics in the Social Security Administration (in H.E.W.) from 1953 to 1956. He is on leave from the University of Michigan where he was Professor of Public Welfare Administration (1956–1961). Author of *Retirement Policies in Social Security*, he has published many articles on medical care for the aged.

[4] *Aging in a Changing Society,* Eleventh Southern Conference on Gerontology, University of Florida, 1962, p. 95.

[5] *Background Studies Prepared by State Committees for the White House Conference on Aging,* Report by the Subcommittee on Problems of the Aged and Aging to the Committee on Labor and Public Welfare, U.S. Senate, 1960.

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"History shows that government control over health care is either the first step or one of the early steps toward government domination over all aspects of a people's life."

Government Health Care: First the Aged, Then Everyone

By Edward R. Annis
President, American Medical Association

For the past three or four years one of the most controversial topics of discussion in this country has been the question of how to finance health care for the aged. The health and health care of the nation's population over 65 is, of course, a major subject in itself. It deserves serious, careful consideration on a basis of reason and facts rather than emotion and political motives.

It becomes an even more significant issue, however, when it is considered in relation to the much broader question of altering the Social Security system to accommodate a program of complete medical care for all of the American people. How the more immediate issue is resolved will determine the eventual answer to the much bigger question.

The course of events during recent years bears a strangely ominous resemblance to the path marked out by Arthur J. Altmeyer, former United States Commissioner for Social Security. In a 1954 Public Affairs pamphlet entitled "Your Stake in Social Security," Mr. Altmeyer charted the future as follows:

> Eventually our first line of defense against hardship and want will be a comprehensive contributory social insurance program that offsets income losses due to unemployment, disability, old age, and death, and helps meet the costs of medical care. How long it will take such a system to develop is not clear, but it will eventually develop. Probably, like other countries, we shall continue to meet particular needs, one by one. Then we shall find we have many gaps and inconsistencies among the provisions. Finally we shall find it simpler and more effective to eliminate these complications by adopting a comprehensive, unified program.

In general terms, that blueprint expressed the shift of strategy which followed the Truman administration's failure to enact a national compulsory health program. That effort, from 1949 to 1952, was blocked by an upsurge of public opinion which clearly demonstrated the American people were strongly antagonistic to the concept of government control of medicine. Then came the tactical switch from the frontal attack to the more subtle methods of the piecemeal approach.

The latest chapter in this story of government encroachment began in 1957 with the introduction of the Forand Bill. This proposal would have provided certain hospital, surgical and nursing home benefits to persons eligible for Social Security retirement payments. Several variations and compromise versions of the Forand Bill later were introduced in the 86th Congress.

Instead of these proposals involving large-scale federal expenditures, Congress in the 1960 post-convention session passed the Kerr-Mills Medical Assistance to the Aged Bill. The Kerr-Mills Act has been supported by

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the American Medical Association since its inception because it is aimed toward helping the minority of elderly people who really need help—the indigent as well as those who can meet day-to-day living expenses but could not finance a major medical expense.

KERR-MILLS ACT

Since the fall of 1960, less than three years ago, the states have implemented the Kerr-Mills Law faster than other grant-in-aid programs. As this article was written in April, 1963, a total of 44 states, containing 93 per cent of all Americans over age 65, had acted upon one or the other, or both, parts of the Kerr-Mills Law. An additional 16 states were considering legislation.

Nevertheless, the proponents of Social Security health care for the aged have steadfastly refused to grant that the Kerr-Mills program has any merit or should be given any consideration. The King-Anderson Bill, a watered-down version of the original Forand proposal, was introduced in the 87th Congress and was the focus of debate in 1961 and 1962. During that period it was snubbed by the House Ways and Means Committee, defeated in compromise form by the United States Senate and vetoed by public opinion. The Gallup Poll showed that public support for the King-Anderson program dropped from 67 per cent in 1961 to 44 per cent in August, 1962.

However, the effort continues. The King-Anderson Bill was reintroduced this year in the 88th Congress with only superficial changes and variations. In its basic provisions and philosophy it is the same as the proposal that was rejected last year.

An obvious attempt has been made by the authors of the new King-Anderson Bill to conceal the grant of power which would be extended to the Secretary of Health, Education and Welfare to interfere with administration and medical practice in participating hospitals. Soft words, however, do not conceal the harsh fact that this new legislation still contains that dangerous grant of power. Altered language has not removed the fundamental objections to this bill.[1]

1. Government control, which would be established by this bill, is not compatible with good medicine. Bureaucratic regulation cannot be mixed with medicine without diluting the quality of medical care. In this case, furthermore, the availability of medical services to the aged would be governed by the availability of tax money, not by the medical needs of these citizens. If quantity is thus restricted, quality will inevitably suffer.

2. Increased taxes imposed on workers and employers would be used to purchase specified health benefits for everyone over 65, regardless of financial need. The use of tax funds for services to the wealthy and well-to-do along with the needy cannot be justified economically or morally. The argument that a means test for hospitalization is degrading and undignified is political hypocrisy.

3. The King-Anderson Bill is not only unnecessary, it is pointless. The needs of the elderly in financing medical care are being met substantially. More than 60 per cent have health insurance protection, and this protection is expanding rapidly, both in numbers covered and extent of coverage. More than two million over 65 receive medical care through Old Age Assistance. The Kerr-Mills law is available for the remainder of the aged who need help with their medical bills. More than 93 per cent of the aged live in states which have taken advantage of all or part of Kerr-Mills.

4. The King-Anderson law fails to measure up to the Kerr-Mills law in a fundamental test—the extent of benefits. The Kerr-Mills program is designed to provide full medical care to all over 65 who need help. The King-Anderson program, on the other hand, would cover less than 25 per cent of the annual medical expenses of the average person over 65.

5. No one really knows how much a King-Anderson type program would cost the taxpayers. The Administration's $1.5 billion a year prediction is obviously unrealistic, since sponsors of this legislation have ad-

[1] Statement, American Medical Association, Ways and Means Committee, House of Representatives, on H.R. 4222, 87th Congress, August 2, 1961.

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vanced the same figure for every bill since 1957, ignoring both rising prices and variations in provision of the legislation. Experienced actuaries figure the first-year cost of the current legislation at $2.5 billion or more. Nevertheless this program, if enacted, would begin with a $35 billion debt. That's the amount H.E.W. calculates would be required to provide lifetime benefits to the 18 million aged who would be immediately eligible, most of whom would have paid nothing for the benefits.

As surely as night follows day, enactment of Social Security health care for the aged would bring constant political pressure for further expansion. With all covered persons paying a higher Social Security tax, but with benefits limited to a particular age group, it is not difficult to imagine the inevitable political appeal of expanding both benefits and eligibility.

Therefore, how the current issue of health care for the aged is met will determine whether or not government medicine for all Americans will be avoided.

FOUR MAJOR FACTORS

Four major factors must be weighed and valued if full-scale nationalized medicine is to be averted: the quality of health care, the cost, the philosophy involved and, most important of all, the programs that already exist.

The experience of many other countries, recorded in a massive array of books, articles and reports, demonstrates that the delusion of government medicine lies in its promise of good health care at little or no cost to the individual patient. The actual result, however, is a mediocre kind of care for all patients, at a high, constantly increasing cost to all taxpayers.

Under any system involving compulsion and control, the patient first of all loses freedom of action and choice in the conduct of his personal health affairs. He becomes another unit in a mechanical procedure which undermines the personal relationship between patient and physician. The end product is a routine, standardized type of health care which erodes quality as it whittles down the quantity of medical services available. As Helmut Schoeck pointed out last year in a comprehensive appraisal of foreign programs:

> Many of those "civilized countries" which have government medical care are currently, and have been for years, engaged in a bitter fight to dig out from under what has become a crushing, stifling, near bankrupt, health bureaucracy that has little to do with good medical care.[2]

Over and above those practical results, there is an intangible effect which lies in the realm of philosophy. Political realities being what they are, it is virtually impossible to abandon a system of government-controlled health care once it has been established. The delusion of "free" medical service—the false euphoria of medical security—persists. The politicians in power either foster that delusion or lack the courage to reshape the system.

The system therefore stumbles from crisis to crisis, accompanied by repeated promises of improvement. Meanwhile, the philosophy of the system undermines the public's sense of personal responsibility in matters of health care. Eventually, the philosophy of government-provided security spreads to corrupt the people's outlook on all socio-economic problems.

In this prosperous country, built on a foundation of initiative, independence, individual freedom, and voluntary effort, there is no need to risk the faults and deficiencies which are inherent in compulsory programs of health care. In fact, it would be national folly to abandon New World progress and embrace regressive methods of the Old World.

The United States has the world's highest standards of medical education and health care. No nation, anywhere, has ever achieved a fraction of the growth and development which we have accomplished in the field of voluntary health insurance and prepayment plans to protect people against the costs of illness. Through voluntary efforts, supplemented by sound, well-aimed government

[2] Helmut Schoeck, editor, *Financing Medical Care*, The Caxton Printers, Ltd., Caldwell, Idaho, 1962.

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programs, the United States is moving swiftly ahead in all vital areas: expansion of medical schools; recruitment of medical students; construction of hospitals, nursing homes and other medical facilities; medical research, and assistance for all people who really need help.

These are programs attuned to the American tradition and personality, which preclude any need for adventures in the highly dubious area of compulsory health care for all.

THE QUALITY OF CARE

The United States Supreme Court has ruled that the government has the right to regulate that which it subsidizes. The record shows that government-financed medical systems directed by bureaucrats usually impose a tremendous amount of regulation, red tape and paperwork upon practicing physicians. This robs them of valuable time needed for the careful examination, diagnosis and treatment of patients. Then, patients who need close attention have to compete for the doctor's time with the whole gamut of people who have only minor complaints, imaginary ailments, trivial requests, or just a desire to "cash in" on whatever benefits are available.

That means overcrowded waiting rooms, overworked doctors, and the gnawing problem of how to apportion time and services. The over-all result, despite the best efforts of conscientious physicians, is a tendancy toward quick examinations, snap diagnoses, palliative treatments and excessive referrals to specialists and hospitals. Medicine becomes a mass-production, assembly-line procedure in which quantity takes precedence over quality and both suffer. While the conscientious doctors worry over what they may have missed in the rush of a day's work, patients lose their identity as whole personalities. Emphasis shifts from the care of individuals to the volume of "cases."

The situation is further aggravated when a patient is referred to a specialist, clinic or hospital, loses contact with his original physician, becomes embroiled in the red tape of waiting lists, and eventually comes under treatment by medical personnel he has not chosen and who are unfamiliar with his physical, mental and emotional history. The main harm under such conditions falls upon the sincere, well-meaning patients who require proper care for illness or personalized attention for the maintenance of good health.

Under compulsory government medicine the demand skyrockets but the supply of medical services does not and cannot grow in proportion. The rush for prescriptions, eyeglasses, dentures, medical appliances and whatever benefits may be available tends to weaken and undermine the over-all structure of a nation's health program. Public health work, research, preventive medicine, industrial health, school health programs, dental care for children, hospital construction and similar basic projects are usually neglected.

For example, during the first 14 years of the British National Health Service, only one general hospital was built in the entire British Isles. During that same period more than 760 new hospitals were built in the United States. As recently as April 20, 1963, it was reported from London that "staff shortages in Britain's nationalized hospitals keep 27,000 beds idle at a time when some 400,000 await treatment."[3]

THE COST OF THE CARE

If the quality of medical care did not suffer under government control, possibly there would be some justification for increased costs. However, the combination of mediocre service at a higher price works a double injustice to the taxpayers. The record shows that government planners always underestimate the cost of their medical programs.

In Great Britain, the first year of the National Health Service cost almost twice the original estimate. Soon the annual cost was running triple the estimate, and it became necessary to place a ceiling on the medical budget and financial curbs on certain benefits. In recent years the British system has been costing more than double the first

[3] Chicago Tribune Press Service, Chicago Tribune, April 21, 1963.

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full year of service, or in excess of four times the original estimate. This has been the story from Germany to New Zealand and in practically every country which ever ventured into the maze of government medicine. As Melchior Palyi, internationally known economist and student of socialized medicine has pointed out:[4]

> While the medical schemes are new and fresh, the difficulties are expected to be smoothed out in due course. Instead, they tend to grow more serious as time passes. The oldest in Germany and Austria have acute troubles to face, as have the latest in Belgium and Britain. Remarkable is the similarity of the problems in spite of all differences in national temperament, historical and political background, legislation and administration, personnel and institutions. Whether the plan is drawn up as governmentalized insurance based upon payroll taxes levied on employers and employees, as an over-all security scheme carried by the general taxpayer, or as a compromise form, skyrocketing costs seem to be a curse that cannot be banned unless the doctors are thoroughly curbed and/or the functions of the scheme are profoundly curtailed.

Here in the United States, the proponents of a national compulsory health scheme estimated in 1949 that it would cost about $6 billion per year and could be financed by a 4 per cent payroll tax. The estimate, of course, was meaningless to begin with, because the people already were voluntarily spending over $7 billion annually for personal health services. Now, however, the American people are spending over $21 billion a year on health care.

The total cost and the Social Security tax rate necessary to finance a national compulsory health system cannot be predicted with accuracy. It is impossible to foresee exactly the amount of abuse, overutilization and high administrative expense to be expected under such a government program. Nevertheless, it is a conservative, realistic estimate that the annual cost would go far beyond $20 billion per year and would require at least a 10 per cent total payroll tax as a starter.

The American people must bear in mind that the Social Security tax already is scheduled by law to reach a total of 9.25 per cent in 1968. Thus, with the addition of Social Security health care for all, the prospect would be a payroll tax of at least 20 per cent, and probably higher, shared equally by employer and employee—with the employer's share passed on to all consumers in the form of higher prices.

Actually, the situation could become much worse, if the social planners are not held in check. *Nation's Business,* in a 1955 study, estimated that the ultimate Social Security program envisioned by Mr. Altmeyer and others would require a minimum payroll tax of 30 per cent and possibly 40 per cent. That would mean from 15 to 20 per cent for an employee, and an even higher amount for a self-employed person.

Two more recent studies have emphasized the ultimate financial dangers involved in indiscriminate expansion and alteration of the Social Security system, including full medical care benefits. Ray M. Peterson, one of the nation's top insurance executives, warns: "Our social security system can be preserved only if we keep benefits within the limits of carefully defined social objectives."[5] *U.S. News & World Report* points out: "In each case, planning rests on the idea that future generations will get and pay much of the bill for those who are getting, or stand to get, the bargains of the present."[6]

Already, under present law, some workers pay more in Social Security taxes than they do through income taxes. With compulsory health insurance added, millions of people in the low and middle income groups would find their Social Security tax substantially higher than their income tax. This would impose a much greater burden on the average citizen than the comparatively modest cost of a sound voluntary health insurance plan. The well-meaning, provident taxpayer—the

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[4] Melchior Palyi, *Compulsory Medical Care and the Welfare State,* National Institute of Professional Services, Chicago, 1950.

[5] Ray M. Peterson, "The Coming Din of Inequity," *Journal of the American Medical Association,* April 8, 1961.

[6] "The Untold Story of Your Social Security," *U.S. News & World Report,* July 2, 1962.

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real forgotten man—would lose the most under government medicine.

THE PHILOSOPHY INVOLVED

The question of philosophy is far more pertinent and practical than it may sound. History shows that government control over health care is usually either the first or one of the early steps toward government domination over all aspects of a people's life. Here, as in many other countries, the proposals for government health care did not arise as a separate and distinct issue—based purely and simply on medical care problems. There is no medical crisis here, nor is the country confronted with any serious, critical shortcomings which require a radical change in our system of health care.

Like similar plans in other nations, the proposal in this country arose as part of a trend based on the philosophy that individual freedom and initiative must be subordinated to government authority and regulation. This "big brother" concept, if allowed to spread unchecked, undermines self-reliance, and fosters the habit of turning to government for the solution of all problems.

In this process, described by the late Albert Jay Nock, editor and author,

> the state turns every contingency into a resource for accumulating power in itself, always at the expense of social power; and with this it develops a habit of acquiescence in the people. New generations appear, each temperamentally adjusted or "conditioned" to new increments of state power, and they tend to take the process of continuous accumulation as quite in order.[7]

As a result, new dangers arise in the form of inflation, paralyzing taxation, ever-increasing government domination, and a growing bureaucracy with far-reaching, arbitrary powers—dangers from which the individual cannot escape by his own efforts.

In his book, *The Constitution of Liberty,* Professor F. A. Hayek of the University of Chicago puts it this way:

> It has been well said that, while we used to suffer from social evils, we now suffer from the remedies for them. The difference is that, while in former times the social evils were gradually disappearing with the growth of wealth, the remedies we have introduced are beginning to threaten the continuance of that growth of wealth on which all future improvement depends . . . we are now raising new giants which may well prove even greater enemies of a decent way of life.[8]

This trend—this philosophy of government intervention—must be resisted, not only in the field of health care but all along the line of American life. In medicine and health, citizens of the United States can be proud of past and present progress. At the same time, whatever gaps or deficiencies exist must be corrected. The best hope of *continued, accelerated* progress—and the solution of health problems in a manner most satisfactory to the majority of the people—lies in the *improvement* of the present system, not in the substitution of alien concepts.

The growth of voluntary health insurance, which already has proved its worth and appeal on the American scene, has been spectacular, especially since World War II, and it continues to expand and improve.

Fifteen years ago, at the end of 1947, about 52.5 million people—30 per cent of the population at that time—had some form of coverage, and the proponents of compulsory health insurance were claiming that voluntary plans had just about reached the limit of their potential.

(*Continued on page 119*)

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[7] Albert Jay Nock, *Our Enemy, The State,* Caxton Printers, Ltd., Caldwell, Idaho, 1950.

[8] F. A. Hayek, *The Constitution of Liberty,* The University of Chicago Press, Chicago, 1960.

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"National Health Insurance is . . . a means of diverting increased resources to the treatment of disease," this specialist points out. Nonetheless, "the development of strong insurance companies that cater to those who want medical insurance and the growing strength and mobilization of the American Medical Association have pretty well excluded the possibility of a national insurance program now or in the immediate future."

National Health Insurance?

By Seymour E. Harris
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In the late 1940's there was a strong movement to introduce National Health Insurance in the United States.[1] In fact, President Roosevelt, in his original Social Security Act, had an opportunity to introduce some form of health insurance. The opposition of vested interests resulted in his abandoning the plan, although, looking backward, it is probable that he could have introduced a program at that time. In the late 1940's I was in favor of National Health Insurance, and testified to this effect before a Senate Committee.

But the situation has changed a great deal since the 1940's, because there has been a tremendous development of private insurance. In 1948, various private plans provided only $606 million of benefit expenditures for health. By 1961, the figure was $5.7 billion. In 1948, the benefits under insurance amounted to 8 per cent of the $7.6 billion of private expenditures for medical care. By 1961, $5.7 billion amounted to more than one quarter of the $21.1 billion of private expenditures for medical care.

What is more, the per capita private expenditures for medical care had risen from $52.80 in 1948, to $116.60 in 1961. This is a rise that is much larger than the increase in the per capita disposable income, and suggests some improvement in medicine. We should allow, however, for the fact that there has been considerable inflation in medical expenditures; medical prices have risen much more than the general price level. But, in general, the higher the standard of living the larger amounts of income available for such items as housing, medicine and education.

The development of strong insurance companies that cater to those who want medical insurance and the growing strength and mobilization of the American Medical Association have pretty well excluded the possibility of a national insurance program now or in the immediate future. In terms of practical politics it seems to be completely hopeless at the present time.

One may compare the British system which went into effect soon after World War II. The British on the whole have had a very successful health program despite some misleading propaganda in the United States. Just in the last year the major medical associations in Great Britain issued a statement, after careful study, to the effect that the National Health Service in Great Britain was here to stay and that the country could not do without it. Indeed, the medical associations suggest many improvements. But on the

[1] For development of many of these subjects see my book, *The Economics of American Medicine*, Macmillan, September, 1963.

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whole there is strong support for the program, and there has been strong support by doctors and patients in overwhelming numbers—as revealed by numerous polls.

The situation in Great Britain is somewhat different than in the United States. First, the per capita income and standard of living are much lower, and therefore the need for protection against these unexpected expenditures in medicine is much greater. Moreover, there has not been the kind of private insurance development in Great Britain that there has been in this country, and therefore the task of a national program is much greater. A third point to be noted is that the British have, in general, depended heavily upon consumption taxes on alcohol and tobacco and similar semiluxuries. With the revenue received from these taxes the Government provides subsidies that are required to make the health insurance service operate effectively. In other words, the Government forces a redistribution of spending between alcohol, tobacco, other luxuries and medicine.

THE FAILURE OF PRIVATE INSURANCE

I do not mean to say that there is not a strong case for National Health Insurance, for there really is. The case rests largely on the fact that there is still much illness that is not covered by insurance, and unless some alternative approaches can be found it may still be necessary to have some kind of a national program.

The weakness of our present position is that comprehensive private health insurance is very expensive and not widely available. In its famous report to President Truman in early 1953, the President's Commission on the Health Needs of the Nation emphasized especially the need for comprehensive private health insurance. This was the central point in the recommendation, but comprehensive private health insurance is still a very unimportant item in the total picture. It has not moved ahead as had been hoped early in the 1950's.

Many explanations are available for this failure. The first is that real comprehensive medical insurance is expensive. One must realize that with per capita private expenditures of $116, it would be necessary to spend something like $400 per family to achieve an adequate comprehensive health insurance program. This would include preventive medicine, a limited amount of dentistry, expensive drugs, as well as hospital and physicians' care. (The assumption would be that the patient would pay a given sum before the insurance company covered any of the costs.) Particularly in the area of dentistry, nursing and long-term illness there are serious gaps in our insurance programs. Moreover, the coverage for ordinary services of doctors is not all that it might be.

A second reason for the failure of comprehensive health insurance has been a certain amount of opposition, particularly from local medical societies. This is made very clear in the experiences of the program in New York, H.I.P. Doctors joining the Health Insurance Program were subjected to persecution by members of the local societies, were denied access to hospitals and were treated badly in other ways. Many doctors, fearful of this kind of ostracism, are afraid to join a comprehensive health program.

Still another factor is, of course, that people just are not ready to pay a few hundred dollars a year for medical insurance. They prefer to take their chances rather than to give up some current luxury. For certain groups the problems are even more serious. The unemployed certainly cannot afford to pay a few hundred dollars for comprehensive health insurance. Nor, for that matter, can most of the old or other disadvantaged groups.

In recent years the major controversy has been over Medicare, that is, compulsory health insurance under the Old Age and Survivors' Insurance Program. Organized medical groups have been strongly opposed to any Medicare program, largely on the ground that this would be an entering wedge for a National Health Insurance Program. It may well be that the organized medical groups are right in their estimation of the significance of a Medicare program. There is no doubt, on the basis of past experience, that any par-

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ticular government program tends to expand and cover more ground.

But I am inclined to argue in a somewhat different way. My view is that if we had a good Medicare program, taking care of the most vulnerable groups, those in the 65 and over age group, then to that extent the movement for a national program would be greatly weakened. It is the most important and the most costly gap in our health financing coverage.

It is hardly necessary to state the case for Medicare. The elderly have roughly about one-half as much income as the average population, and from two to three times as much illness and days in the hospital; their diseases are likely to be of the degenerative type which takes many months to cure, or need treatment as terminal diseases. Unless some way is found to provide private insurance for the masses at a price that they can afford to pay, including comprehensive health insurance programs subsidized to some extent by the government, the pressure for a more all-around program will steadily increase.

RISING COSTS

Another factor making for government interference is the rising price of medicine. This increase in price is especially evident in hospital care. Rising costs of the hospital bed are related in part to the general inflation, in part to the low, depressed pay of hospital employees in the past, which is now gradually being corrected, partly to the increased services required in the hospital, and partly because of new developments in science which make very expensive treatments possible. In general, the number of employees in relation to the number of patients has greatly increased in recent years, reflecting improved care and increased complications of treatment. The new wonder drugs, the antibiotics, are also increasingly expensive.

Indeed, one may well say that this is not so serious as it seems to be because the per capita income rises at such a rapid rate that in relation to a day's work the cost of medicine has not really risen. Perhaps a better way of putting this is to say that the consumer of medical services does not profit from his rising standard of living, as he does, for example, when he purchases a pound of meat or a seat at the baseball game.

One may raise the question as to why there should be National Health Insurance under any conditions. Of course, if one has a strong preference toward a free market and is fearful of government, one is not likely to have much to say in favor of National Health Insurance. If, however, one feels that adequate treatment of the sick is the responsibility of society in the same way that society is concerned with adequate education, then perhaps one may be more enthusiastic about National Health Insurance.

National Health Insurance is, in a sense, a means of diverting increased resources to the treatment of disease. By imposing taxes on the American people, say a payroll tax of one or two or three per cent, the government may, through various private agencies primarily, provide necessary medical services. The compulsion lies only in the fact that everyone has to pay the tax, and the tax would be shared by employer and employee. But the effect would be to pour much more money into the medical field. This, of course, has been one of the effects of private insurance, and it certainly has been a very important effect of National Health Service in the United Kingdom. So the major contribution of National Health Insurance is to provide a large pool of resources to pay the necessary services of the ill.

Another important advantage is that under a National Health Insurance program it would not be necessary to charge the same price to all consumers. For example, the charge might be 2 per cent of payroll: if the worker receives $1,000 a year he pays $20, and if he receives $5,000 a year, he pays $100. Under private insurance it is more difficult to discriminate in this manner. Actually, under Blue Cross there has been a practice of charging the same price, irrespective of the risks involved. This is a form of price discrimination and underlines the quasi-public attitude of Blue Cross.

In recent years, private insurance com-

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panies have tended to take away a good deal of the least risky business of the Blue Cross, and for these particular groups the private insurance companies tend to charge lower prices. In other words, they base their pricing on experience with illness and the likely cost. It therefore becomes increasingly difficult for Blue Cross to do what could be done under National Health Insurance, namely, to maintain a discriminatory price system, or what amounts to the same thing: charging the same price irrespective of the differences of cost.

If one is to establish a National Health Insurance Program, it is important to be careful that large amounts of additional cash are not poured into the medical market to increase the amount of inflation. Against the increased amount of spending there must be a rise in the supply of services, namely hospitals, doctors, dentists, drugs and the like. For this reason, should a National Health Insurance Program ever become the law of the land, it would be wise to introduce the program slowly. Even under Medicare, it may be wise not to introduce a complete program the first year. It might be wise to limit the program the first year to those over 70, the second year to those over 68, and the third year to those over 65. In this way, a gradual adjustment could be made to provide the necessary care, particularly hospital beds that would be required to satisfy the needs of older citizens.

HIGHER INCOME FOR DOCTORS?

One factor that tends to increase enthusiasm for a national program is the large rise in the income of doctors. This is not, by any means, entirely the doctors' fault. One of our problems is that there is not a sufficient capacity to turn out the number of doctors required in the economy. It has been estimated that by the early 1970' we shall need an increased output of doctors of 50 per cent to maintain the present ratio of doctors to population. According to *Medical Economics,* the average private practicing physician earns $25,000 a year, which is at least three times as much as the average member of a college faculty, or more than twice as much as the average lawyer.

Many doctors are embarrassed by these high returns. They profit from the operations of a free market. But in a sense the market is not free because it is not easy to increase the total supply of medical students in response to increased incomes. The government is making progress in this area, but very slowly; it has not always had the cooperation of the American Medical Association in trying to achieve a greater capacity. It should be said to the credit of physicians that, though their incomes have risen a great deal, they also work much harder than they used to. When one allows for the increased number of working hours, their excess of income is not so large as it seems to be. I feel reasonably sure that many of them would be much less embarrassed if their incomes were cut to some extent by an increased supply of physicians.

Large incomes, of course, go especially to the specialists, and the proportion of specialists is gradually increasing. In some of the major medical schools there is scarcely a general practitioner turned out any more. But the difference in income between the specialist and the general practitioner has been gradually reduced. It was not very long ago when the average specialist earned about 80 per cent more than the average general practitioner. At the present time the differential seems to be of the order of about 25 per cent.

Despite the large incomes of doctors, the price for services has not gone up nearly so much as many other medical items. The doctor works longer hours and spends less time per patient per visit. He also makes much better use of the medical team, and therefore saves his own energies. But the net effect of all this is that the doctors' share of the medical dollar pool becomes larger: whereas doctors are rather restricted in supply, it is easier to increase supplies of nurses, technicians, and other members of the medical team.

Under the National Health Insurance Program, doctors would probably not be paid a

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fee per service as they generally are now. Nonetheless, in the American economy doctors, to a greater extent than previously, now work for salaries, in hospitals, in medical schools and on research. The high income of doctors also makes it very difficult for medical schools to obtain adequate talent for teaching. Pressed by the great need for research and also the increased demand for doctors in the hospitals, the medical schools face very serious problems of providing the necessary personnel to turn out an adequate supply of high quality doctors.

One of the points that has been used against introducing a National Health Insurance Program in the United States has been the apparent failure of the British National Health Service. As I said above, there has really been no serious failure. In fact, on the whole the system has been highly successful. It is well to point out some of the differences between medicine in Britain and in the United States.[2] Under the British National Health Service, the patient is now really able to make use of specialists to a degree that was not possible before. Indeed, to some extent, the great increase in the supply of specialists' services is not really an increase, but merely a change in classification.

Nevertheless, there has been a considerable improvement. What the medical program in Great Britain has done for the British people is to increase the resources in medicine and to achieve a much better distribution of medicine than had prevailed before. It should be noted that improved distribution has also come as a result of the many private insurance programs in the United States. Perhaps distribution has not improved so much as we would like, but it certainly has improved.

In conclusion, there is a case for National Health Insurance, but it is not nearly so strong a case as one could have made in the 1930's or the 1940's. Great expansion of insurance under private auspices, the rising standard of living of the American people and their capacity to increase their contribution toward medical expenditures out of their current income—these, in general, weaken the case for National Health Insurance. The mobilization of strong lobbying influence by the American Medical Association and related organizations, and the powerful pressures of the insurance companies make it less than likely that a National Health Insurance program will become available in the near future. If we can greatly improve our private health insurance and provide subsidies for those who cannot really afford any form of comprehensive health insurance, then the case for National Health Insurance will be greatly weakened. I believe that the strongest case for federal government intervention lies in the area of medical services for the old. Should this area be covered, then the case for National Health Insurance would also be further weakened.

One must not be too optimistic on the basis of the British experience. The case for the Health Service in Great Britain is much stronger than in the United States, both because of British methods of financing and because of the lower standard of living and the relatively small inroads of private insurance. The British have shown that a National Health Service program can remove the dollar sign from medicine, can provide fair income to the purveyors of medical services, and can increase the total amount of medicine, as well as improve its distribution.

The British National Health Service has been one of the great contributions to the advance of welfare programming in the last generation. It remains to be seen whether the United States, with minimum intervention on the part of the government, can provide a similar improvement in medicine and in distribution of medical service.

[2] On the N.H.S., see also our July, 1963, issue.

Chairman of the Harvard Department of Economics, **Seymour E. Harris** has been a member of the faculty since 1922. He has served often as a consultant to government agencies. Editor of *The Review of Economics and Statistics,* he is the author of 25 books on economics. Among his latest publications are *The Economics of the Political Parties* and *The Economics of American Medicine* (Macmillan, November, 1963).

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The Hospital Insurance Bill of 1963

Section 1709, Parts (c)-(g)

A bill to provide payment for medical care for the aged under the social security program (the King-Anderson Medicare bill) was introduced in Congress in February, 1963. Sections 1701 through 1705 and section 1709 (a) and (b) appeared in our July issue. Section 1709, parts (c) through (g) are reprinted in full below:

"Amount of Payment for More Expensive Services

"(c) (1) In case the bed and board furnished as part of inpatient hospital services or skilled nursing facility services is in accommodations more expensive than two-, three-, or four-bed accommodations and the use of such more expensive accommodations rather than such two-, three-, or four-bed accommodations was not at the request of the patient, payment with respect to such services may not exceed an amount equal to the reasonable cost of such services if furnished in such two-, three-, or four-bed accommodations unless the more expensive accommodations were required for medical reasons.

"(2) Where a provider of services with which an agreement under this title is in effect furnishes to an individual, at his request, items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under this title, the Secretary shall pay to such provider of services only the equivalent of the reasonable cost of the items or services with respect to which payment under this title may be made.

"Amount of Payment Where Less Expensive Services Furnished

"(d) In case the bed and board furnished as part of inpatient hospital services or skilled nursing facility services in accommodations other than, but not more expensive than, two-, three-, or four-bed accommodations and the use of such other accommodations rather than two-, three-, or four-bed accommodations was neither at the request of the patient nor for a reason which the Secretary determines is consistent with the purposes of this title, the amount of the payment with respect to such services under this title shall be the reasonable cost of such services minus the difference between the charge customarily made by the hospital or skilled nursing facility for such services in two-, three-, or four-bed accommodations and the charge customarily made by it for such services in the accommodations furnished.

"No Payments to Federal Providers of Services

"(e) No payment may be made under this title (except under subsection (f) of this section) to any Federal provider of services, except a provider of services which the Secretary determines, in accordance with regulations, is providing services to the public generally as a community institution or agency; and no such payment may be made to any provider of services for any item or service which such provider is obligated by a law of, or a contract with, the United States to render at public expense.

"Payment for Emergency Inpatient Hospital Services

(*Continued on page 120*)

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THE NATION'S HEALTH

(*Continued from page 70*)

benefits have accrued from our health services. There is also a general consensus that on an average our facilities are better today than 30 years ago, and our physicians, dentists, nurses, pharmacists and all other personnel are better trained. In addition, drug therapy has made enormous strides.

The very effectiveness of our health services has resulted in increased cost and increased demand so that we live in a paradoxical situation of greater public concern even though health services are better than ever before. Now, one of our main problems is how to maintain and improve the health services so that they can continue to meet the demands made on them. The amount of money necessary to do this is unresolved since no one knows how much money a good health service should cost. The extent to which services should be paid for by insurance is gradually approaching resolution. The form the organization of physicians should take is unresolved, but all of these problems are being examined and discussed endlessly. There is, however, more ground for optimism that these problems will be resolved than for pessimism as long as our present dynamism continues.

THE NEW DEAL

(*Continued from page 86*)

cal services, the less presumably would remain of the traditional entrepreneurial individualism.

Unacknowledged by the A.M.A. was the *de facto* erosion of this individualism. Progress in medical science and technology, accompanied by specialization, rising costs of good medical care, and the special problems posed by the increasing proportion of aged and chronically ill, were leading inexorably toward the bureaucratization of medicine: group clinics, hospital leadership in diagnosis, treatment and research, group insurance to eliminate the threat of catastrophic cost, and increasing government expenditures at all levels for health and medical services. The A.M.A.'s success in scuttling the national health program hardly affected these impersonal forces leading to bureaucratization, centralization and some combination of universal voluntary and compulsory insurance. The medical profession simply lost an opportunity to help guide those forces rationally and efficiently, insuring in the process a satisfactory remuneration, status and authority for the physician.

H.E.W.: FIRST DECADE

(*Continued from page 91*)

the Joint Commision on Mental Health, attempts have been made with increasing success to send patients to non-medical facilities. Several new buildings have been opened, the older buildings have been refurbished, and appropriations made for a psychological rehabilitation center.

Comments have been made that the Department is too large and it is frequently suggested that the Department be split into three separate departments. It is the judgment of those who have had experience in the top administrative positions, however, that it would be a mistake to separate the agencies. While the functions are widely diversified, in practice it has been found that many of these functions are closely related, more so than in some other departments. It has been found that the views of those active in one area have been helpful in reaching policy decisions in other fields.

It should be realized that unlike other countries which have separate departments for each of these three responsibilities, our federal government's responsibility is limited, with the primary responsibility belonging to the state and local governments. The function of the federal government is mainly one

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of leadership and stimulation, and over-all action only in specific problems that can only be handled on a nationwide basis.

The success of the Department since its inception and of the individual agencies over the prior years has to a large extent been due to the dedicated efforts by the civil servants. A number of the civil servants in top administrative positions have remained with the agencies through the years and provide a strong leadership core, with comparatively little change occurring with the changes in administrations.

The Secretary of the Department, however, is handicapped by a lack of adequate assistants in the appointive positions. This could be corrected by the addition of probably two assistant secretaries to the present staff. As a Secretary has to delegate much of his responsibility to the heads of the five principal agencies, he should be adequately equipped with a staff of appointed assistants to maintain adequate liaison with the individual agencies, with the White House, other departments, Congress, public organizations which are particularly interested in the Department, and the American public in general.

With their widespread effects on individuals, members of Congress are naturally very much interested in the programs of the Department, as are also many organizations of the public. In general, the relationship between the Department and these various groups has been good. Congress, except for a few striking exceptions—such as aid to public schools—has generally supported the recommendations of the Department.

Thus, on the whole, the conclusion is that good progress has been made by the Department in accomplishing the objectives of its original sponsors. There are many unsolved problems, however, in all these agencies—such as hospital care for the aged. To continue this progress, the Department in the future must be alert to adapt its programs quickly to changing conditions, to discontinue those which are no longer productive, and to initiate new programs to meet new conditions.

VOLUNTARY HEALTH INSURANCE

(*Continued from page 97*)

matters are far from solved. We know that the public is demanding more and more health care, and wants higher and higher standards of care for its health dollar. We also know that expenditures for health care are increasing, and will continue to increase for some time.

The total expenditure for health care made by all prepayment agencies has increased almost ten-fold in the past ten years: from $606 million in 1948, to $5.695 billion in 1961. The percentage of consumer income allocated to health care also is increasing, as is the proportion of expenditure that is being made through the voluntary prepayment agencies, which is growing at a much faster rate.

The push for expansion of prepaid benefits will continue until all costs of health care that cannot be met conveniently out-of-pocket at the time of illness can be brought within the scope of prepaid protection. Today, 26.2 per cent of consumer expenditures for health care are made on a prepayment basis. Ten years ago, only 10.4 per cent of such expenditures were made in this way. Certainly, figures for the early 1970's will show similar gains for the prepayment method of purchasing health care.

MEDICAL CARE FOR THE AGED

(*Continued from page 103*)

been demonstrated. It is this same demonstration of need that now calls for the improvement of the basic retirement benefit by adding to it hospital insurance. The addition of hospital insurance is consistent with the increases in benefits made in 1950, 1952, 1954, and 1958 and with the addition of disability insurance protection to the program in 1956.

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Social security protection has important advantages over public assistance. Social security would avoid the application of a means test, which most people find distasteful and humiliating; it would cover the cost of quality care in every state of the Union; it would cover the cost of care at the time when it was needed without delays for investigation of financial capacity; it would provide no disincentive to savings or personal and employer arrangements for additional protection, which would make the individual ineligible for aid under a means-test program; it would, most important, eliminate the widespread fear among the aged that an expensive illness would reduce them to abject poverty.

Finally, hospital insurance for the aged under social security would fit into the existing pattern. It would work side by side with private insurance just as retirement benefits and private pension plans have worked together. It would relieve public assistance of a great part of its present burden and permit the states to offer truly meaningful aid to the few in specially disadvantaged circumstances. It would provide a basic benefit that could readily be supplemented on a private basis. It would encourage free choice of doctor and hospital by removing cost barriers that now stand in the way of such free choice.

It is for all these reasons that the President has said of his proposal, "Health insurance for our senior citizens is the most important health proposal pending before the Congress. We urgently need this legislation—and we need it now."

GOVERNMENT HEALTH CARE

(*Continued from page 109*)

At the end of last year, 140 million persons —more than 75 per cent of the population— had some form of voluntary protection against the costs of illness. In addition to 140 million with hospital insurance (seven times the number in 1942), 130 million also had surgical coverage, 97 million had regular medical expense protection, and 38 million had major medical expense insurance, a rapidly-growing form of coverage that was practically unknown a dozen years ago.

Approximately 1,800 companies and prepayment plans were providing this insurance in 1962. They were expanding all along the line, in hospital, surgical, medical, major medical and loss-of-income insurance. They paid over $7 billion in benefits, an increase of 11.5 per cent in just one year.

On top of the 75 per cent with insurance protection, medical costs for another 9 per cent of our people are financed by public assistance programs, the armed forces, institutions and other public programs. This leaves only 16 per cent of the population unprotected, including about 5 million retired persons.

However, our elderly citizens are buying health insurance at a faster rate than the rest of the population. Ten years ago, only 26 per cent of the aged were covered. Today, at least 60 per cent—about 10.5 million out of 17.5 million—have protection. Insurance experts predict that, among the aged who need and want it, coverage will reach at least 70 per cent by the end of 1965 and 90 per cent by 1970.

New forms and combinations of health insurance are being developed for all age groups. Experimentation is under way in the use of voluntary plans under public assistance programs, including Kerr-Mills help for the aged. All of this progress demonstrates that the American public likes voluntary methods and that private enterprise has the ability to satisfy the public's needs.

This is the safe, sensible path for Americans —rather than the drabness and dangers which would accompany national compulsory health care. As a true liberal, the late Justice Louis Brandeis of the U.S. Supreme Court, once warned:

"The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well meaning but without understanding."

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"(f) Payments shall also be made to any hospital for inpatient hospital services or outpatient hospital diagnostic services furnished, by the hospital or under arrangements (as defined in section 1703 (f)) with it, to an individual entitled to health insurance benefits under this title even though such hospital does not have an agreement in effect under this title if (A) such services were emergency services and (B) the Secretary would be required to make such payment if the hospital had such an agreement in effect and otherwise met the conditions of payment hereunder. Such payment shall be made only in amounts determined as provided in subsection (b) and then only if such hospital agrees to comply, with respect to the emergency services provided, with the provisions of section 1710 (a).

"Payment for Services Prior to Notification of Noneligibility

"(g) Notwithstanding that an individual is not entitled to have payment made under this title for inpatient hospital services, skilled nursing facility services, home health services, or outpatient hospital diagnostic services furnished by any provider of services, payment shall be made to such provider of services (unless such provider elects not to receive such payment or, if payment has already been made, refunds such payment within the time specified by the Secretary) for such services which are furnished to the individual prior to notification from the Secretary of his lack of entitlement if such payments are not otherwise precluded under this title and if such provider complies with the rules established hereunder with respect to such payments, has acted in good faith and without knowledge of such lack of entitlement, and has acted reasonably in assuming entitlement existed."

* * *

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THE MONTH IN REVIEW

A CURRENT HISTORY Chronology covering the most important events of June, 1963, to provide a day-by-day summary of world affairs.

INTERNATIONAL

Berlin

June 15—Mayor Willy Brandt departs for Berlin after a week's visit to the U.S.

June 22—Western Allies protest East Germany's new Berlin Wall restrictions. East Germany has sealed off a strip about 100 yards wide along the Communist side of the wall. The border area will be restricted to allied personnel. A 500-meter wide area along the East German-West Berlin border has also been sealed off.

June 26—U.S. President John F. Kennedy is greeted by West Berliners and tells crowds that "all free men, wherever they are, are citizens of Berlin."

Disarmament

(See also *U.S. Foreign Policy*)

June 11—It is reported from Washington that U.S. President John F. Kennedy has named W. Averell Harriman to head the U.S. delegation to negotiate in Moscow in July with the Soviet Union and Great Britain on a nuclear test ban agreement.

June 14—Soviet Premier Nikita Khrushchev denies that international inspection is needed in the event of a nuclear test ban.

June 20—The U.S. and the U.S.S.R. sign a pact setting up an emergency communications link, a so-called "hot line," between Washington and Moscow to reduce the danger of accidental war.

June 21—The 17-nation disarmament conference in Geneva recesses.

European Economic Community (Common Market)

June 17—U.S. Secretary of State Dean Rusk tells the Senate Foreign Relations Committee that unless Common Market nations ease restrictions on U.S. farm products, the U.S. may find it necessary to "withdraw concessions already given" to such nations.

International Labor Organization

June 15—Nigerian Labor Minister Joseph Johnson resigns as president of the I.L.O.'s 47th session because of an African decision to boycott the session as long as a South African delegate is present.

June 20—The Soviet Union is defeated in a move to adjourn the I.L.O. conference in support of the African boycott. The 1964 budget of $16.9 million is adopted over Soviet protest.

June 26—The I.L.O. ends its conference.

North Atlantic Treaty Organization

June 21—The semi-official French Press Agency announces that France will withdraw its available Channel and Atlantic naval forces "from the NATO Fleet in the North Atlantic," except for some submarines.

Organization of American States (O.A.S.)

June 5—An 8-nation special investigating committee appointed by the O.A.S. Council reports that Communist subversion in Latin America, with a Cuban base, "has increased considerably during the past year."

June 17—Bolivia formally withdraws from the Council of the O.A.S. because of O.A.S. "mishandling" of the border dispute with Chile.

United Nations

(See also *Yemen.*)

June 3—Reliable sources at the U.N. disclose U.S. plans to give a special donation of

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something less than $2 million for U.N. forces in the Congo and the Middle East for the second half of 1963.

June 11—Poland reveals that she will not pay U.N. assessments for the Congo or Middle Eastern U.N. forces, nor will she pay assessments representing the Polish share of interest and principal on U.N. bonds to cover the deficit from the peace-keeping forces.

June 12—The U.S.S.R. contends that the U.N. cannot deny voting privileges if a member is 2 years in arrears on its U.N. assessments; only a two-thirds vote of members present and voting can sanction such denial.

June 14—France charges that the General Assembly cannot force members to pay assessments for peace-keeping operations; only the Security Council can make such mandatory decisions.

June 27—The U.N. General Assembly adopts 2 resolutions providing that members be assessed $42.5 million for U.N. forces in the Congo and Middle East for the last 6 months of 1963. The special session of the Assembly adjourns.

ARGENTINA

June 20—A decree aimed at eliminating Peronists from the election on July 7 is issued. The decree enables the government to declare invalid the electoral slates of parties associated with Peronists.

BOLIVIA

(See *Int'l, O.A.S.*)

BRAZIL

June 17—President João Goulart reorganizes his Cabinet.

June 19—Carvalho Pinto accepts the job of finance minister; he will replace Francisco San Tiago Dantas.

BRITISH COMMONWEALTH OF NATIONS

Canada

June 19—The Government drops its 30 per cent tax on sales to a foreigner of shares in a Canadian company totaling $50,000 or more in one day. The withdrawal is termed "temporary." The tax was to be imposed to stop U.S. take-over of Canadian corporations.

Great Britain

June 5—Admitting that he lied to Parliament about his relations with model Christine Keeler, John Profumo resigns as Secretary of State for War.

June 10—A conference on an independent West Indian Federation has been postponed, it is announced in London.

June 12—Queen Elizabeth entertains Indian President Sarvepalli Radhakrishnan.

June 13—Because of growing unrest, 500 British troops are airlifted to Swaziland.

June 17—After more than six hours of debate on the Profumo scandal, Prime Minister Harold Macmillan's government receives a narrow margin of support in Commons, 321–252.

June 21—Macmillan tells the Commons that Lord Denning will head a judicial inquiry investigating the "security aspects" of the Profumo case.

June 27—Macmillan names Minister of State for Foreign Affairs Joseph Godber to replace Profumo as War Secretary.

Malaya

(See also *Indonesia.*)

June 7—At the opening session of a ministerial conference of Indonesia, Malaya and the Philippines, Indonesia and the Philippines modify their opposition to the proposed Malaysian Federation of Malaya, Singapore and three British possessions in Borneo.

Pakistan

June 8—Finance Minister Mohammad Shoaib announces tax increases amounting to 300 million rupees ($63 million) for fiscal 1964.

BRITISH EMPIRE

British Guiana

June 11—British troops are called to guard Georgetown's power plant and other crucial points; this is the first use of British troops in the general strike.

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June 13—The Trades Union Council gets a request from Prime Minister Cheddi Jagan to set a date to negotiate an end to the 54-day-old general strike called by the Trades Union Council to protest a law giving the Government control of labor unions. Strikers are asking Jagan to resign.

June 16—Janet Jagan, wife of the Prime Minister, is named Minister for Home Affairs, responsible for security.

June 18—Governor Sir Ralph Grey ends Parliament's session.

Federation of Rhodesia and Nyasaland

June 18—Prime Minister of Southern Rhodesia Winston Field tells the Legislative Assembly in Salisbury that he will attend the conference on Federation dissolution. Southern Rhodesia's franchise enables 233,000 whites to control some 3.6 million Africans.

Kenya

June 1—Jomo Kenyatta is sworn in as Kenya's first Prime Minister.

June 5—Meeting in Nairobi with Jomo Kenyatta, Uganda's Prime Minister Milton Obote and Tanganyika's President Julius Nyerere reveal their commitment to the establishment of an East African federation before the end of 1963.

Zanzibar

June 24—Internal self-government begins. Prime Minister Mohammed Shamte's government is sworn in.

CHINA, PEOPLE'S REPUBLIC OF (Communist)

June 16—*Hsinhua* (official Chinese press Agency) publishes a letter sent on June 14 by the Central Committee of the Chinese Communist party to the Central Committee of the Soviet Communist party. The letter outlines the Chinese view on the ideological differences between the 2 countries, and lists 25 questions to be discussed at the ideological conference scheduled for July 5.

June 18—The Central Committee of the Soviet Communist party issues a statement attacking the Chinese letter; the statement declares that China has violated the agreement to halt "open" ideological criticisms.

June 23—Ending an 18-day visit to China, North Korean President Choe Yong Kon signs a declaration with Chinese Communist chief of state Liu Shao-chi.

June 29—It is revealed that the Soviet government has demanded that 5 Communist Chinese, 3 of them officials of the Chinese embassy, be recalled.

CONGO, REPUBLIC OF THE (Leopoldville)

June 14—President Moise Tshombe of former secessionist Katanga Province flees the Congo.

June 15—Evariste Kimba becomes acting president of Katanga Province.

June 25—The Congolese parliament abolishes the state of South Katanga Province, which was led by Tshombe. Parliament approves a bill incorporating 2 territories in North Katanga with South Katanga to form the new state of East Katanga.

Tshombe remains in a hospital in Paris where he has been permitted to seek treatment for an intestinal problem.

CUBA

June 3—Cuban Premier Fidel Castro arrives in Cuba from the Soviet Union, ending a visit that began April 27.

June 24—Manuel Antonio de Varona is elected president of the Revolutionary Council, replacing Antonio Maceo.

ECUADOR

June 10—U.S. tuna boats report that they are leaving Ecuador.

FINLAND

June 17—Vaino Tanner, Chairman of the Social Democratic party, retires. He is succeeded by Rafael Paasio. Vaino Leskinen is not re-elected to the executive committee. Tanner and Leskinen are 2 of 4 Social Democrats whose removal had been demanded by the Soviet Union.

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FRANCE

(See also *Int'l, Nato*)

June 14—The National Assembly ratifies the Franco-German treaty of cooperation by 325 votes to 107 (with 42 abstentions).

June 21—Voting 163–69, the French Senate ratifies the Franco-German treaty.

June 27—Minister of Information Alain Peyrefitte, in an address, voices French doubts that U.S. President Kennedy's pledge to defend West Europe will be binding on his successor. (See *U.S. Foreign Policy.*)

GERMANY, DEMOCRATIC REPUBLIC OF (East)

June 30—In East Berlin, Soviet Premier Khrushchev confers with Polish leader Wladyslaw Gomulka, Czech leader Antonin Novotny, Hungarian leader Janos Kadar, Bulgarian leader Todor Shivkov, and East German officials.

GERMANY, FEDERAL REPUBLIC OF (West)

June 12—Government press spokesman Karl Gunther von Hase tells a news conference that West Germany has given $9.6 million in military aid to 7 African nations.

June 23—Cheering West German crowds welcome visiting U.S. President Kennedy.

June 24—A West German peace corps, officially called "Overseas Teaching and Aid Development Service," is inaugurated.

A joint communiqué is issued by West Germany and the U.S. listing their agreement on European union and a strong Nato alliance.

June 28—West German Foreign Minister Gerhard Schroeder, speaking in Düsseldorf, declares that it is inconceivable that the U.S. would not fight for its European allies.

GREECE

June 11—Premier Constantine Caramanlis resigns after King Paul refuses to cancel his trip to Britain scheduled for next month.

June 17—Panayotis Pipinelis, a member of Caramanlis' National Radical Union, is asked to form a caretaker government.

June 18—Pipinelis declares he will accompany the King and Queen on their British visit.

June 19—Pipinelis' Cabinet is sworn in.

HAITI

June 3—The U.S. government announces that it will "resume normal diplomatic business" with Haiti.

June 4—It is reported from the Dominican Republic that peasants' homes along the frontier have been burned by soldiers sealing off a 2-mile wide zone along the border.

June 14—In a note from Haiti to the U.S., Haiti requests the removal of U.S. Ambassador Raymond L. Thurston and anounces the recall of her ambassador to the U.S. (See also *U.S. Foreign Policy.*)

ICELAND

June 9—Elections for a new parliament are held.

June 11—Election returns reveal that the coalition of Premier Olafur Thors' Independence party and the Social Democratic party won 32 seats in the 60 seat parliament.

INDONESIA

June 1—Two U.S. and 1 British oil companies sign an agreement with Indonesia.

June 11—Foreign ministers of Malaya, Indonesia and the Philippines announce a proposed mutual defense treaty to protect their countries from subversion; they urge a "confederation of nations of Malay origin"; they express agreement on their conflict over the projected federation of Malaysia (composed of Malaya, Singapore, North Borneo, Sarawak and Brunei).

June 27—President Sukarno returns home from his 2-month trip to Europe and the Far East.

IRAN

June 5—Some 20 persons are killed or injured as government forces quell rioting members of the Shiite Muslim sect.

IRAQ

June 7—Ending a 3-day conference of Syrian and Iraqi leaders, a joint communiqué is

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issued urging the U.A.R. to negotiate differences over their proposed union.

June 10—The Iraqi government announces war against the Kurdish troops under Mullah Mustafa al-Barzani, who desires autonomy.

ISRAEL

June 12—Two Israelis are found guilty by a Swiss court for threatening the daughter of a West German scientist working in the U.A.R.

June 16—For "personal" reasons Premier and Defense Minister David Ben-Gurion resigns; he also resigns his parliamentary seat.

June 17—Ben-Gurion withdraws his resignation from parliament.

June 19—President Zalman Shazar asks Finance Minister Levi Eshkol to form a cabinet.

June 26—The Knesset (parliament) approves Premier Eshkol's government.

ITALY

June 18—Premier-designate Aldo Moro ends efforts to form a coalition government.

June 19—President Antonio Segni asks Giovanni Leone, speaker of the Chamber of Deputies and a Christian Democrat, to form a Cabinet.

June 21—Leone selects a cabinet composed entirely of Christian Democrats.

June 22—The new Cabinet is sworn in.

LAOS

June 8—Premier Phouma declares that he has rejected a Pathet Lao proposal to hold negotiations at Khang Khay (Pathet Lao headquarters at the Plaine des Jarres).

June 14—British and Soviet Ambassadors fly to Pathet Lao headquarters to arrange negotiations between Pathet Lao leader Prince Souphanouvong and neutralist Premier Prince Souvanna Phouma.

MOROCCO

June 29—King Hassan II departs from France. A joint communiqué announces that France has agreed to extend its aid to Morocco.

PERU

June 9—Elections for a president, 2 vice-presidents, senators and deputies are held.

June 11—With almost 90 per cent of the total vote counted, Fernando Belaunde Terry (backed by the Popular Action-Democratic Christian party coalition) receives 627,694 votes. His nearest rival wins 520,213.

June 15—Almost complete official returns disclose that the Popular Action-Christian Democratic coalition has won 20 of the 45 Senate seats, and 70 of the 140 seats in the Chamber of Deputies.

PHILIPPINES, THE

(See *Indonesia*)

SYRIA

(See *Iraq*)

SWEDEN

June 25—The Swedish government announces that it has arrested Colonel Stig Wennerstrom (a disarmament specialist) on charges of having spied for the Soviet Union for 15 years.

U.S.S.R., THE

(See also *China*)

June 10—Soviet Premier Nikita S. Khrushchev talks with visiting British Labor party leader Harold Wilson.

June 15—Lieutenant Colonel Valery F. Bykovsky orbits the earth in Vostok V. Bykovsky, fifth Soviet astronaut, began his space travels yesterday.

June 16—Junior Lieutenant Valentina V. Tereshkova, the first female astronaut, is launched into orbit in the spaceship Vostok VI. *Tass* (Soviet press agency) reports that Tereshkova's craft is orbiting near Bykovsky's; the 2 astronauts have communicated by radio. They send a joint message to Khrushchev.

June 19—Tereshkova and Bykovsky land in the Republic of Kazakhstan in Central Asia 3 hours apart. Tereshkova orbited the earth 48 times in some 71 hours; Bykovsky's 5 days in space set a new record (he orbited earth 81 times).

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June 21—Ending 4 days of plenary meetings, the Central Committee of the Communist party announces that Leonid I. Brezhnev has been elected to the Secretariat of the Central Committee. Brezhnev is chairman of the Presidium of the Supreme Soviet (titular head of state). Party chief of the Ukraine Nikolai V. Podgorny is also elected to the Secretariat.

June 28—Khrushchev arrives in East Berlin and is welcomed by First Secretary of the East German Communist party Walter Ulbricht.

June 29—The World Women's Congress ends its meeting in Moscow with shouting and voting down of the Albanian and Communist Chinese delegations.

UNITED ARAB REPUBLIC

(See *Yemen.*)

UNITED STATES

Civil Rights

(See *Segregation.*)

Foreign Policy

June 1—President Sarvepalli Radhakrishnan of India arrives for a 10-day state visit.

June 10—President Kennedy asks for a "strategy of peace" to end the cold war; he says the U.S. will refrain from atmospheric nuclear tests if no other nation begins to test; he reveals plans for a high level Big Three meeting in July to discuss a nuclear weapons test ban.

June 14—At Haiti's request, the U.S. Ambassador is withdrawn from Port-au-Prince. (See also *Haiti.*)

June 22—President Kennedy leaves for a 10-day visit to Europe.

June 23—Kennedy tells the Germans that the U.S. will keep its troops in Europe as long as necessary. (See also *Int'l, Berlin* and *West Germany.*)

June 25—In Frankfurt, President Kennedy calls for a "fully cohesive Europe that can join an equal partnership with the U.S."; he tells Europeans the U.S. will "risk its cities to defend yours."

June 26—Kennedy arrives in Ireland.

June 30—President Kennedy and British Prime Minister Harold Macmillan agree that a nuclear test ban is essential, in a communiqué issued after their London talks.

Government

(See also *Civil Rights.*)

June 10—The President signs into law a bill guaranteeing women equal pay for equal work.

Richard I. Phillips is named to succeed Lincoln White as official State Department spokesman. White has been named consul general to Melbourne, Australia.

June 29—The President signs an act to continue "Korean War" excise taxes and corporate income taxes.

Labor

(See also *Segregation.*)

June 4—A federal grand jury indicts International Brotherhood of Teamsters President James R. Hoffa and 7 others of a $20 million fraud in union pension funds.

June 7—Pan American World Airways and two unions agree on a new contract abandoning their rights to strike or lock-out during negotiations.

June 15—At the President's request, 5 train operating unions and the nation's railroads agree to try until July 10 to settle their work rules controversy.

June 29—Eleven major steel corporations and the United Steelworkers of America reach agreement on labor contract revisions to last at least until May 1, 1965. No wage increases are provided; an extended vacation plan is set. For the first time in the history of steel negotiations, no strike or threat of strike accompanied this agreement.

Military Policy

June 20—A naval court of inquiry reports that the "most likely" cause of the loss of the submarine *Thresher* April 10 was a piping system failure.

Politics

June 4—New York's Governor Nelson Rockefeller says that his attitude toward the

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1964 presidential race has not changed because of his recent re-marriage.

June 17—Pennsylvania's Governor William Scranton says he will be available as a favorite-son candidate for the presidential nomination in 1964.

June 22—The Republican National Committee chooses San Francisco for its 1964 presidential nominating convention.

June 25—The Democratic National Committee chooses Atlantic City for its 1964 presidential nominating convention.

Segregation and Civil Rights

June 3—Four Arkansas state laws that suppressed activities of the National Association for the Advancement of Colored People are ruled unconstitutional by the Arkansas Supreme Court.

June 4—President Kennedy orders a review of all federal construction programs to end discriminatory hiring practices.

June 5—Cleve McDowell, a Negro, enters the University of Mississippi without incident.

Negro students enroll at Chattanooga University in Tennessee for the first time.

A biracial Goodwill Committee announces desegregation of the "larger and nicer" hotels, motels and restaurants in Winston-Salem, North Carolina.

June 9—The President tells the National Conference of Mayors that increased local responsibility is needed in this "moment of moral and constitutional crisis" in race relations.

June 11—President Kennedy tells the nation that a "moral crisis" faces Americans because of the rising Negro protest.

Confronted by federalized National Guard troops, Governor Wallace steps aside and allows 2 Negro students to enrol in the University of Alabama after he physically blocks the entrance.

June 12—N.A.A.C.P. field secretary Medgar W. Evers is shot in the back and killed in Jackson, Mississippi.

June 13—Public swimming pools are integrated in Atlanta, Georgia, without incident.

Some 50 restaurants, motels, hotels and theaters agree to desegregate their facilities in Greensboro, North Carolina.

June 15—After 27 Negroes are arrested for demonstrating at the funeral of Medgar Evers, hundreds of Negroes riot.

June 18—The New York State Department of Education asks local school districts to accelerate plans for ending racial imbalance.

June 19—President Kennedy asks Congress for civil rights legislation including among other provisions a legal guarantee to all citizens of equal access to privately owned hotel, restaurant, and amusement facilities and to retail establishments in inter-state commerce; he asks also for broader powers for the Attorney General in school desegregation suits.

June 21—In Cambridge, Maryland, the City Council and Negro leaders agree to an "80-day cooling-off period"; a referendum will be held on an anti-discrimination amendment to the city charter.

The presidents of 18 unions in the construction industry announce a program to end racial discrimination in union membership, apprenticeship, and job assignments.

June 22—President Kennedy orders the Secretary of Defense to act within 30 days on complaints of racial bias within the military as reported by a special committee.

In a White House meeting with 30 Negro and white civil rights leaders including the Reverend Martin Luther King, President Kennedy is notified that Negro demonstrations will continue until civil rights issues are resolved.

June 23—In Gadsden, Alabama, Negro leaders declare that mass demonstrations will be renewed; negotiations to end racial problems have failed.

Byron de la Beckwith is arrested for the murder of Medgar W. Evers.

June 24—Negroes and whites march in downtown Los Angeles protesting discrimination.

A Federal District Judge rules that Prince George County, Virginia, cannot

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discriminate against children from the Fort Lee army base because it accepts U.S. funds for the education of these children.

June 26—Kentucky Governor Bert T. Combs signs an executive order prohibiting state-licensed businesses from racially discriminatory practices.

Supreme Court

June 3—The Court rules that a school plan that permits pupils to transfer out of schools where their race is in a minority is unconstitutional because it leads to "perpetuation of segregation."

The Court votes 7–1 to uphold a special master's recommendation on division of water from the Colorado River, rejecting California's claim that the Colorado's tributaries, principally the Gila in Arizona, should be included in the apportionment.

June 10—The Court rules 8–1 that state law enforcement officers are subject to the same constitutional restrictions in making arrests as federal officers.

June 14—Without explanation, the Court denies a petition to set aside a Mississippi state court injunction to prevent Negro demonstrations in Jackson, Mississippi, without a permit.

June 17—Ruling in 2 cases, the Court declares 8-1 that no state or locality may require the recital of the Lord's Prayer or Bible verses in public schools.

VATICAN, THE

June 3—Pope John XXIII, 261st Pope, dies.

June 19—80 Cardinals enter into conclave to elect a new Pope.

June 21—On the fifth ballot, the Sacred College of Cardinals elects Giovanni Battista Cardinal Montini, Archbishop of Milan, Supreme Pontiff of the Roman Catholic Church. He takes the name of Pope Paul VI.

June 22—Pope Paul VI announces that he will continue Vatican II, the Ecumenical Council convened by Pope John XXIII.

June 30—Paul VI is crowned.

VIETNAM, SOUTH

June 12—Buddhist flags are flown in memory of a Buddhist priest who burned himself to death yesterday in protest against the government of President Ngo Dinh Diem (Roman Catholic). One of the points at issue is the Buddhists' right to fly their flag.

June 14—South Vietnamese officials meet with Buddhist delegates for negotiations.

A U.S. army captain is killed by Viet Cong (Communist) guerrillas.

June 16—Violent outbursts occur in Saigon between Buddhists and police. Using tear gas and clubs, security forces restore order.

YEMEN

June 7—U.N. Secretary General U Thant announces that Major General Carl Carlsson von Horn, head of the U.N. Truce Supervision Organization in the Middle East, will leave for Yemen shortly. He reports that the U.A.R. and Saudi Arabia have agreed to help pay for sending a peace-keeping mission to Yemen. The U.A.R. has sent aid in support of the republican government of Yemen President Abdullah al-Salal; Saudi Arabia supports the royalists under Imam Mohammed al-Badr.

June 8—The Soviet Union requests a Security Council meeting to discuss the peace-keeping mission to be sent to Yemen.

June 11—The Security Council votes approval of the Yemeni peace-keeping operation; the Soviet Union abstains.

June 23—Yemeni tribesmen kill 5 British soldiers and capture 21 other Britons who lost their way while on training maneuvers in Aden.

June 24—President al-Salal leaves Cairo; he is accompanied home by 3 U.A.R. leaders.

YUGOSLAVIA

June 16—Voting is held in the final stage of elections that began on May 24 for the Federal Peoples Assembly (parliament).

June 29—The Federal Assembly meets and elects Edvard Kardelj its president.

June 30—The parliament elects Aleksandar Rañkovic vice-president of Yugoslavia.

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